Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303998042M
Compliance #: HL303994101

Date Concluded: February 14, 2025

Name, Address, and County of Licensee Investigated:
Vista Prairie at Goldfinch Estates
850 Goldfinch St
Fairmont, MN 56031
Martin County

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

Evaluator's Name: Lena Gangestad, 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 by punching the wrong Lorazepam (Ativan) bubble pack, attempting to put it back, and accidentally inserting a different medication instead of Ativan.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP, who was an unlicensed caregiver whose duties included medication passing, made an error when he punched out Ativan by mistake. The AP then made an additional mistake when he attempted to put the medication back but put the wrong on in the bubble pack. No harm occurred to the resident and the error was isolated.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident's records, internal

investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia, restlessness and agitation. The resident's service plan indicated the resident required assistance with medication management.

The facility's incident report indicated the nurse was informed a dose of as-needed Ativan had a piece of tape behind it in the as-needed medication bubble pack. Upon examination, the nurse found the medication taped in the bubble pack was not Ativan but Lasix.

The resident's physician order sheet indicated that the resident had an order for Ativan 0.5 milligrams (mg) twice a day and an additional Ativan 0.5 mg tablet once daily as needed for aggression, with a required interval of 4-6 hours between scheduled doses.

During an interview, a manager stated that the incident was reported to the nurse after it was noticed that the resident's as-needed Ativan pill in the bubble pack did not look the same as the other pills and an internal investigation was initiated during which the AP was interviewed. The AP said he accidentally taken the as-needed Ativan instead of the scheduled Ativan. Upon realizing the mistake, he attempted to put the medication back and taped it to the back of the pack. However, the medication he put back was Lasix, not Ativan. A comparison of the pills found they looked in color and shape, both being round and white. Subsequently, the facility provided the AP a corrective action and re-assigned to duties which did not include medication passes. All staff members were educated on the importance of reporting medication errors to the nurse immediately, and a sign was posted as a reminder.

During an interview, the nurse stated controlled medications [such as Ativan] medications were stored in a locked drawer in the med cart, with both PRN and scheduled medications stored together, making it possible to mistake one for the other.

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.

(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(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 loss
Family/Responsible Party interviewed: No. attempts were not successful.
Alleged Perpetrator interviewed: No; attempts were not successful.

Action taken by facility:
The facility initiated an internal investigation. The resident was assessed, and the physician was notified. Staff education was provided, and the AP was removed from medication cart duty.

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
	30399	A. BUILDING: _____ B. WING _____	C 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GOLDFINCH ESTATES	850 GOLDFINCH STREET FAIRMONT, MN 56031

(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 Jan 21, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL303998042M/ HL303994101C. No correction orders are issued.	0 000		