Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319496708M
Compliance #: HL319491153C

Date Concluded: March 11, 2025

Name, Address, and County of Licensee Investigated:
The Waters of Highland Park
678 Snelling Ave South
St. Paul, MN 55116
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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), a facility staff member neglected the resident when the AP administered incorrect medication to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the medication error occurred, the error was an isolated incident. Upon discovery of the error, the AP immediately notified the facility nurses, emergency medical services, and the resident was sent to the hospital for evaluation. The resident returned to the facility the next day at her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, and related facility

policy and procedures. Also, the investigator observed medication administration by a facility staff member.

The resident resided in an assisted living facility. The resident's diagnoses included altered mental status and chronic kidney disease. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was independent with dressing and transferring. The resident's assessment indicated the resident had mild cognitive impairment.

An incident report indicated one evening the resident received the wrong medications. The resident received another resident's medication that included atorvastatin (for high cholesterol) and donepezil (used for Alzheimer's disease). The resident experienced nausea, vomiting, and an increase in body heat. Facility staff arranged for the resident to be evaluated at a hospital..

The hospital record indicated the resident arrived at the emergency room. The resident was experiencing vomiting most likely due to a side effect of donepezil. The resident was treated with intravenous fluids, anti-nausea medications, and observation. The resident was discharged back to the assisted living the next day.

During an interview, leadership stated when the AP made the medication error, the process for medication administration for staff was to keep the medication cart in a central area on the top floor of the facility. After staff set up the medications, they would have to take the residents' medications down two floors. In the process, the AP forgot whose medication she had and gave the wrong medications to the wrong resident. After the incident, the process was changed, and staff are required to pass the residents medication with the medication cart just outside of each residents' apartment. Leadership stated the AP was retrained on medication pass. The AP had no prior medication errors before the incident and no medication errors after the incident.

During an interview, the AP stated at the time of the incident, the medication cart with all the facility residents' medication was kept on the memory care unit. The AP stated, staff would set up the medications for residents not in the memory care unit in medication cups, place the room number on the paper cup, and deliver the medications for the residents. The AP stated at that medication pass she set up two separate resident medications and delivered them in the cups to a different floor. Both residents had two medications each. The AP recognized her error after giving the resident the incorrect medications. The AP stated she called an on-call nurse right away and when the resident stated she was not feeling well, the resident's vital signs were checked, and the resident was sent to the hospital. The AP stated it was not intentional, she made an error and reported the error to an on-call nurse right away. The AP stated following the medication error, staff now take the medication cart with them to each resident apartment.

During an interview, a family member stated the resident returned to her baseline condition.

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 resident was sent to the hospital and AP was retrained on the medication administration. In addition, the facility required staff to no longer park the medication cart in one location. The staff are required to pass medications to residents with the medication cart outside of the resident’s apartment.

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
	31949	A. BUILDING: _____ B. WING _____	C 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF HIGHLAND PARK	678 SNELLING AVENUE SOUTH SAINT PAUL, MN 55116

(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 February 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL319496708M / #HL319491153C. No correction orders are issued.	0 000		