Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53066102M
Compliance #: H53063380C

Date Concluded: December 9, 2025

Name, Address, and County of Licensee Investigated:
Edenbrook of Rochester
1875 19th Street NW
Rochester, MN
Olmstead County

Facility Type: Nursing Home

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), a registered nurse, failed to provide appropriate care and services as ordered for a resident with hypoglycemia (low blood glucose) and wound care. The resident was transferred to the emergency department (ED) and hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to notify the provider as ordered when the residents blood glucose was 54. When rechecked, the resident's blood glucose was 39, and the AP failed to call the provider as ordered and administered 2 medications (used to lower blood glucose) to the resident. 45 minutes later the AP administered glucagon (an emergency medication to raise blood glucose). Although the resident's blood glucose briefly increased to 86 (after glucagon was given) the resident later required transfer to the ED, was hospitalized, and treated for persistent hypoglycemia.
No neglect related to wound care was identified.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), emergency and hospital records, facility internal investigation documentation, personnel files, staff schedules, and related facility policy and procedures.

The Centers for Disease Control (CDC) identified severe hypoglycemia (low blood sugar) as blood sugar levels below 54 milligrams (mg)/ deciliter (dL). The CDC identified a severely low blood sugar level as a medical emergency which could lead to unconsciousness, seizures, and death.

According to the Federal Drug Administration (FDA) glimepiride is an antihyperglycemic medication used to lower blood glucose levels which starts working within an hour and has peak concentration of the medication occurring 2 to 3 hours after the dose was taken.

According to the FDA after a glucagon injection the blood glucose concentration rises within 10 minutes, and maximal concentrations are attained about 30 minutes after the injection, with the duration of action of the medication lasting 60 to 90 minutes following administration.

The resident resided in a skilled nursing facility with diagnoses including type 2 diabetes mellitus with hyperglycemia and was admitted to the facility for rehabilitation 2 days prior to the incident following hospitalization/treatment for rhabdomyolysis (a condition in when skeletal muscle breaks down rapidly and can cause acute kidney injury).

The resident's Medication Administration Record (MAR) included orders for 2 oral antihyperglycemic diabetic medications metformin and glimepiride (medications intended to lower the resident's blood glucose) scheduled at 8:00 a.m. and 8:00 p.m.
The MAR included orders to give 40% glucose gel 1 dose orally as needed (PRN) for hypoglycemia blood glucose less than 70 and instructed staff to notify the provider and recheck the resident's blood glucose in 15 minutes and as needed.
The MAR also included orders for glucagon emergency kit intramuscular (IM) injection if the resident was hypoglycemic and unable to consume carbohydrate, as needed for symptoms of hypoglycemia blood glucose less than 70, every 15 min, and instructed staff to call the provider.
The MAR included orders for blood glucose monitoring, scheduled to be done once each shift (day, evening, and night) at the time of the incident.
The order directed staff what action to take if the resident's blood glucose was less than 70, including notify/call the provider and continue monitoring the resident's blood glucose.

The resident's blood glucose and oral intake monitoring record from the day of the incident included the following documentation:

- At 7:59 a.m. the resident's blood glucose was 81. The resident's meal intake record indicated he ate well during the day shift consuming 76-100% of breakfast and the noon

meal. Then, the resident had 51-75% of a snack around 12:45 p.m. prior to the AP coming on shift at 2:00 p.m.

- At 4:50 p.m. the AP documented the resident had a low blood glucose reading of 54. The resident record failed to indicate the AP took action to address the resident's low blood sugar or notify the provider as ordered. The record failed to indicate the AP provided blood glucose monitoring as ordered following a low blood glucose reading of 54, with no blood glucose monitoring documented by the AP until 4 hours and 15 minutes later.
- At 5:00 p.m. the meal intake record indicated the resident consumed 51-75% of his evening meal. However, the AP later documented in a progress note the resident consumed only half a sandwich during the evening meal at 5:00 p.m. The resident record lacked indication the AP took action to ensure adequate intake was offered/provided to the resident after a low blood glucose reading of 54 and poor intake was documented by the AP.
- At 9:05 p.m. the AP documented the resident had a critically low blood glucose level of 39. The resident record failed to indicate what action was taken by the AP at that time including following providers orders to give oral glucose, emergency glucagon, or calling the provider for further direction.

The resident's August MAR indicated at 9:06 p.m. (one minute after documenting the resident had a critically low blood glucose reading of 39) the AP administered 2 oral antihyperglycemic medications metformin and glimepiride. The MAR lacked any documentation to indicate the AP administered glucagon or oral glucose to the resident for hypoglycemia as ordered during her shift.

At 9:45 p.m. a progress note/faxed communication from the AP to the resident's provider indicated at 4:00 p.m. the resident's blood glucose was 54. The note/communication indicated the resident had poor intake for his evening meal. The AP indicated the resident's blood glucose was now 39 and she had administered emergency glucagon (40 minutes after the resident's low blood glucose reading of 39, and 41 minutes after the AP documented giving 2 oral antihyperglycemic medications to further lower the resident's blood glucose, which aligned with the FDA's timeline for onset of action of the resident glimepiride medication). The note indicated the AP would re-check the resident's blood glucose in 15 minutes.

At 10:05 p.m. (20 minutes later) the AP documented in the resident's blood glucose monitoring record his blood glucose had increased to 87 (a normal range), which aligned with the FDA's onset of action time for the glucagon emergency kit, and the AP's progress note for time of administration of glucagon. The resident record failed to indicate the AP provided additional monitoring for symptoms of hypoglycemia or blood glucose monitoring after having a critically low blood glucose and administering glucagon and failed to call the provider as ordered for further direction.

At 12:20 a.m. nurse #3 checked the resident's blood glucose which was 51. Nurse #3 immediately called the provider as ordered for blood glucose less than 70 and was instructed a

provider would call nurse #3 back. A progress note indicated nurse #3 attempted to give the resident orange juice with 2 sugar packets, but the resident was too lethargic, slow to respond to questions, would not follow direction, and fell asleep trying to drink the juice. The note indicated nurse #3 rechecked the resident's blood glucose (7 minutes later), which remained 51 despite attempted interventions, so nurse #3 called 911.

The resident's ED/hospital record indicated the resident was transferred to the ED for hypoglycemia endorsing symptoms including lethargy, weakness, lightheadedness, and dizziness. The resident's blood glucose upon arrival to the ED was 29 prompting administration of intravenous (IV) dextrose (a sterile solution of glucose and water, administered directly into a patient's vein to restore blood glucose levels). The resident was admitted to the hospital for management of persistent hypoglycemia related to the resident's glimepiride medication requiring frequent dextrose injections for 24 hours following the last dose of glimepiride.

A facility investigation root cause analysis indicated the AP did not follow policy or procedure with a hypoglycemic (low blood glucose) event over the course of her shift for a resident with blood glucose less than 70.

Facility investigation documentation included an interview with the AP and facility leadership the day after the incident occurred. At that time the AP stated she checked the resident's blood glucose, which was 54, then she provided the resident his supper. The AP acknowledged she did not notify the provider after the initial low blood glucose of 54. The AP stated at 9:45 p.m. she checked the resident's blood glucose again with the results of 39, then sent a communication to the resident's provider after hours instead of calling as ordered. The AP stated at 10:05 p.m. the resident's blood glucose was 86. The AP indicated she had visualized the resident several times during the shift but denied the resident had symptoms of hypoglycemia.

When interviewed facility leadership stated the AP did not respond to the resident's low blood glucose in an appropriate or timely manner. Leadership stated no contact was made with the resident's provider as ordered other than a faxed note, and the AP failed to document information in the resident record. Leadership stated the AP faxed communication to the provider instead of calling as ordered, and indicated faxing a provider after hours would not result in a timely response. Leadership indicated they expected the AP to have checked the resident's blood glucose, monitored and documented accordingly, followed providers orders, and called the provider for further direction, but the AP did not.

When interviewed the nurse responsible for the resident on the day shift (nurse #1) indicated the resident had good intake with no concerns for low blood glucose during his shift the day of the incident.

When interviewed during a previous federal investigation, facility investigation interview, and maltreatment investigation interview nurse #2 stated she had her own assignment but identified herself as a charge nurse the night of the incident. Nurse #2 consistently stated in

interviews she was unaware and had no communication from the AP about the resident having low blood glucose during the shift until she saw the AP with glucagon in the hallway around 9:30 p.m. Nurse #2 stated at that time the AP stated the resident's blood glucose was 39. Nurse #2 indicated she was shocked and directed the AP to give the glucagon and call the provider. Nurse #2 stated she assumed the AP had done what she was told, then later helped the AP with wound care but did not observe the resident had any symptoms of hypoglycemia at that time.

During a previous federal investigation interview the AP stated the resident's blood glucose at 4:50 p.m. was 54, so she gave him orange juice. The AP stated the resident questioned why he had to drink the juice, and she explained to the resident it was very risky to have blood sugar that low and "if we don't do something he could die from it." The AP stated she never called the provider for further direction for the blood glucose reading of 54. The AP stated the resident then had his evening meal and ate about a half white bread sandwich with ham, mayonnaise, and cheese. The AP explained the resident only ate half the sandwich because he did not like it, and stated she did not offer him any other food. The AP stated she gave the residents metformin and glimepiride, but did not think to call the provider to see if it would be safe to give the medications after the resident had a low blood glucose reading and poor intake. The AP stated she checked the resident's blood glucose level again at 9:30 p.m., (inconsistent from documentation recorded at 9:05 p.m.) and the resident's blood glucose level was down to 39. The AP stated that was when she gave the resident the glucagon injection. The AP could not recall documenting the administration of glucagon on the MAR, and stated she did not call the provider to get further instruction, but rather faxed communication to the provider instead.

When interviewed during the maltreatment investigation the AP provided conflicting information from what was provided during the previous federal interview. The AP stated she checked the resident's blood glucose around 4:00 p.m. and at that time it was 54, so she gave him orange juice with sugar. The AP stated she rechecked the resident's blood glucose and it had increased to 78 (not recorded). The AP stated around 5 to 6 p.m. the resident's blood glucose dropped to 39 (not consistent with the timeline of events according to the AP's documentation in the resident record, faxed communication to the provider, witness statements, or the AP's previous statements). The AP stated at that time she reported the blood glucose to the charge nurse (nurse #2), administered glucagon, and faxed the provider because that was what nurse #2 instructed her to do. The AP also stated she gave oral glucose after the residents evening meal because "he ate poorly", and she "wanted his sugar to be up", however there was no documentation in the MAR or resident record that occurred. When asked to explain the difference in her recollection of what occurred and her documentation in the resident record, the AP stated she did not document the resident's low blood glucose of 39 until 9:00 p.m. because she was busy, then at around 9:30 p.m. the resident's blood glucose was 81 (not recorded) so she administered the resident's oral diabetic meds at that time (inconsistent from previous statements and documentation).

When interviewed during a previous federal investigation, facility investigation interview, and maltreatment investigation interview nurse #3 stated she was assigned to care for the resident

during the night shift. Nurse #3 consistently stated the AP reported during change of shift the resident had low blood glucose and required glucagon during her shift, but had normal blood glucose at 10:00 p.m. Nurse #3 stated when she rechecked the resident's blood glucose (recorded at 12:20 a.m.) it was 51, the resident was "groggy, less alert, with delayed response", so she gave him orange juice and immediately called the provider, and was instructed the provider would call her back. Nurse #3 stated while waiting for the provider to call back she rechecked the resident's blood glucose which remained 51 (recorded 7 minutes later) and called 911. Nurse #3 indicated the resident's blood glucose was 29 when he got to the ED and stated, "that was so dangerous to have a blood sugar that low".

During a previous federal investigation interview the facility medical director stated they expected to be notified if the resident's blood glucose was under 70, and after giving glucagon, especially since the resident was new to the facility and they were unaware of his baseline.

During a previous federal investigation interview the resident had no recollection of the day at the facility when he was sent to the hospital for hypoglycemia (low blood glucose).

A review of the AP's personnel files indicated less than one month following this incident the AP received a coaching/disciplinary action form for another incident involving endangering the safety of another resident, and dishonesty (providing false statement) regarding that resident's coumadin (an anticoagulant medication). The form indicated the AP falsely checked off completing the resident's coumadin orders, then failed to communicate the orders were not completed resulting in the resident missing the medication as ordered for 3 days. The form indicated the incident could have resulted in serious side effects for the resident including blood clots, stroke, and heart attack. The form indicated due to the serious nature of these events and previous similar issues the AP was issued a final warning for her conduct.

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:
When they became aware of the incident the facility suspended the AP pending an investigation into the incident. The facility provided education to the AP and all licensed staff on diabetic management including hypoglycemia/hyperglycemia, notifying the provider of a change in condition, documenting in the resident record, and audited to ensure compliance.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. 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
Olmstead County Attorney
Rochester City Attorney
Rochester Police Department
Department of Human Services (DHS)
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK ROCHESTER WEST	**2215 HIGHWAY 52 NORTH , ROCHESTER, Minnesota, 55901**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H53066102M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for H53066102M, tag identification 21850.	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/05/2025**

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EDENBROOK ROCHESTER WEST	**2215 HIGHWAY 52 NORTH , ROCHESTER, Minnesota, 55901**

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20000	Continued from page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE 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 an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		