Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55491646M
Compliance #: H55496786C

Date Concluded: June 4, 2025

Name, Address, and County of Licensee Investigated:
Good Sam Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159
Cottonwood County

Facility Type: Nursing Home

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

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 staff neglected the resident when they failed to follow the resident's plan of care and provider orders for her continuous blood glucose monitor (CGM) device, that resulted in a hospitalization for sepsis and hyperglycemia (high blood sugar).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Facility staff failed to recognize symptoms of hyperglycemia, did not notify the resident's provider timely to report the resident's continuous glucose monitor's (CGM) readings of low blood sugars, and did not timely perform a manual finger stick blood glucose check to confirm the reading of the CGM. However, the resident's hyperglycemia was precipitated by an infection with an unknown source and unable to determine what reasonable signs of infection would be present. The investigation did not reveal evidence the resident's CGM insertion site was neglected.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included type 1 diabetes, dementia, and hypertensive heart disease. The resident's care plan included assistance with monitoring blood sugar levels, and personal hygiene. The resident's assessment indicated cognitive impairment with forgetfulness and mild confusion, and staff assistance with a walker for walking.

The resident's medication administration records (MAR) indicated the staff were replacing the CGM per the provider's order. The MAR indicated staff were directed to call the resident's provider if the blood glucose reading was less than 60 mg/ml or higher than 400 mg/ml.

The resident's medical record lacked documentation of routine monitoring for hypoglycemia (low blood sugar), hyperglycemia (high blood sugar) or the CGM insertion site by staff.

The resident's progress notes indicated the resident had persistent low blood sugar readings from the CGM for four days prior to being hospitalized. The notes indicated each time the CGM read "LO", nursing staff provided the resident food and drinks in attempt to raise the blood sugar. The notes indicated the nurses administered the resident's insulin per the provider orders. The day prior to her hospitalization, the resident's notes indicated she was noted to appear sleepy, confused, required more assistance with activities of daily living than her baseline, and had complaints of feeling like needing to vomit. The notes indicated her medications were held and the resident was provided a clear liquid diet due to not feeling well. The notes indicated the provider was updated on the resident's change in condition the day prior to her hospitalization, after three days of low blood sugars and not feeling well. The provider ordered lab work, x-rays and changes to medications. The notes indicated a finger stick blood glucose test was performed on the day she was hospitalized, and a "HI" blood glucose result was obtained. The resident was sent to the hospital. Four days of "LO" blood glucose readings, but a manual finger stick reading of "HI" alerted the staff of a discrepancy between the CGM readings and the finger stick readings. The notes indicated the facility received an update from the hospital indicating the resident's blood sugar was over 1000 mg/ml at the hospital.

A facility incident report, completed the day the resident was hospitalized, indicated the resident was noted to have confusion and complaints of not feeling well. The report indicated the provider was in the facility, updated on the resident's condition, and ordered testing for Covid, Influenza and RSV, all of which were negative. The report indicated as the day went on, the resident's CGM alarmed and revealed a "LO" reading. Staff provided glucose tabs and the CGM continued to read "LO." A voicemail was left for the provider. A finger stick blood glucose

test was performed and revealed a “HI” reading. The report indicated the resident was transferred to the emergency room for evaluation.

The hospital record indicated the resident’s hospital stay did not reveal a source of infection, but did reveal evidence of a heart attack. The note indicated the medical team felt the diabetic ketoacidosis (a serious, potentially life-threatening complication when a person’s blood sugar is severely high), was precipitated by sepsis (an infection in the bloodstream) and there were no changes to the resident’s insulin regimen orders upon return to the facility.

The resident’s discharge summary indicated the resident’s primary hospital diagnosis as severe sepsis (systemic infection) due to suspected intra-abdominal infection, and type 2 myocardial infarction with myocardial injury (heart attack).

The user’s manual for the Libre 3 CGM that the resident used, indicated a finger stick glucose test should be performed when you think the CGM readings may not be correct or do not match how the person feels. The manual warns to not ignore symptoms that may be due to low or high blood glucose. The manual indicates if you receive a “LO” or “HI” result, you do not have enough information to make a treatment decision, and a blood glucose test should be performed and treat based on that result.

During an interview, a registered nurse (RN) stated it was her expectation that staff nurses monitor diabetic residents for signs and symptoms of hypoglycemia and hyperglycemia. The RN stated there was not specific training on the Libre 3 CGM; staff were required to read through the manual for the device. The RN stated staff should follow the providers orders of the parameters given on when to call the provider for low or high blood sugar readings. The RN stated the staff started checking the resident’s blood sugar by fingers sticks on routine schedule to confirm the accuracy of the CGM after she returned from her hospitalization.

During an interview, licensed practical nurse (LPN)-1 stated the staff were to read the package insert of the Libre 3 monitor to know what to do, and she had more confidence in knowing how to use it than she should have. LPN-1 stated a finger poke glucose test should be done if the resident had an abnormal reading on the CGM to make sure it was accurate, and the provider should be updated with abnormal readings. LPN-1 stated the resident was a brittle diabetic who could have very high blood sugars and very low blood sugars. LPN-1 stated she did not see any physical symptoms of hypoglycemia or hyperglycemia when she worked with the resident a few days prior to her hospitalization. LPN-1 stated during the time leading up to the resident’s hospitalization, there were many residents who were ill with similar symptoms, so she believed the resident’s diabetic symptoms were overlooked as symptoms of the illness going around.

During an interview, LPN-2 stated did not recall receiving training on a Libre meter. LPN-2 stated she just came off training and was on the floor independently the day the resident was sent to the hospital. LPN-2 stated the resident was not stable with her blood sugars as they quickly go up and down, and the resident showed symptoms of hypoglycemia or hyperglycemia, with

increased confusion being the most notable. LPN-2 stated staff should have done a finger poke on the resident a lot sooner prior to her doing it.

During an interview, LPN-3 stated the resident was a very brittle diabetic who could have a very high blood sugar and drop quickly in 15 minutes. LPN-3 stated she would recognize symptoms of concern in the resident that consisted of increased confusion or complain that she felt sick. LPN-3 stated staff had to self-teach on the use of a Libre monitor, and there was not a policy in place for it at the time of the resident's hospitalization. LPN-3 stated staff checked the CGM insertion site daily but did not recall documenting those checks. LPN-3 stated she never saw signs or symptoms of infection or any other skin concerns at the CGM insertion sites. LPN-3 stated staff would change the CGM monitor every 14 days, or sooner if there were any issues. LPN-3 stated staff put their faith in the CGM and should not have.

The resident was not able to complete a phone interview.

Family did not return the investigator's request for interview.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, unable to complete phone interview.
Family/Responsible Party interviewed: No, did not return request for interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented policy change upon the resident's return to the facility to prevent any future occurrence.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, 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.

You may also call 651-201-4200 to receive a copy via mail or email.

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.

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
	00755	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAK	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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
2 000	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 #H55491646M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		