Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL213871903M
Compliance #: HL213873194C

Date Concluded: July 29, 2025

Name, Address, and County of Licensee Investigated:
Rose Arbor Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator
Rhylee Gilb, 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 facility neglected the resident by failing to provide his medications for over a week due to not obtaining the necessary refills and staff documented administration despite the medications being unavailable.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's medication administration record showed inconsistencies in documentation, where morning staff documented the medication was administered and evening staff documented the medication was not available. Pharmacy records indicated the medication was delivered mid-way through the week of the documented omittance. The facility was issued licensing orders related to their medication administration process during a recent survey. Although, there was four days prior to the delivery of the medication where there was a preponderance

the medication was not available to administer, the resident had no notable adverse effects. The physician decreased the medication to once daily instead of twice daily after notification of the medication error.

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

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living and medication administration.

Review of the medication administration record (MAR) indicated the resident had memantine (medication for Alzheimer's dementia) scheduled twice daily. The MAR indicated from the 18th to the 27th of the month, morning staff charted memantine was administered, while evening staff documented that the medication was not administered due to it being unavailable. On the 27th, the note indicated unlicensed personnel (ULP) notified the registered nurse (RN) and the RN would call the pharmacy.

Pharmacy delivery records indicated memantine was delivered on the 22nd of the month.

The facility's internal investigation indicated the RN investigation the medication error. Review of the MAR and medication cart showed the resident received memantine once a day most days, although it was ordered twice daily. The resident's spouse brought in the medication and had not been notified a refill was needed and the medication should have ran out during the time of the errors. The resident's physician and spouse were notified of the error. The RN assessed the resident and he did not have any notable side effects.

The resident's physician orders indicated the resident's memantine was decreased to once daily after the medication error.

During an interview, ULP #1 stated she was not a certified nursing assistant and had not administered medications in the past 10 years. She said she did not know why her name appeared in the MAR as having administered the resident's medication.

Review of the MAR showed ULP #1 documented administering the medication at 6:00 p.m. on the 23rd of the month.

During an interview, ULP #2 stated the medication was not available. He contacted the nurse, who indicated the medication would be reordered, but the refill never occurred. He stated this issue happened frequently with multiple residents, not just this one. He eventually left the job due to frustration.

Review of the MAR showed ULP #2 and other unlicensed caregivers consistently documented that the medication was not available in the evening from the 18th to the 27th of the month.

During an interview, ULP #3 stated the resident's medication was administered from a bottle. She denied failing to administer the medication and maintained that if she documented it as given, then it was indeed administered.

Review of the MAR showed ULP #3 documented administering the medication at 9:00 a.m. on the 18th and 25th of the month.

During an interview, the facility manager, who is a licensed nurse, acknowledged that medication errors occurred related to memantine. She said the resident was prescribed memantine twice daily, but the MAR showed it was only administered once daily. She stated the supply should have run out by the 18th of the month, but staff continued to chart administration, indicating a discrepancy. She admitted that communication among staff was unclear. She said she spoke with the nurse, who confirmed the last actual dose was administered on the 15th of the month. She suspected that some staff documented medication administration without actually giving it but had no proof. She also stated staff might have ordered the medication from the facility's pharmacy and administered it from the card, but she could not confirm any order was placed from the pharmacy.

During an interview, the resident's family member stated that the manager contacted her to inform her the resident was out of some medications. She said that they determined he had been without memantine and donepezil (medication for dementia) for more than a week. She stated the facility could not tell her when the resident last received donepezil because staff had mixed it in a bottle with another medication. She also reported the facility claimed they had ordered the memantine through their pharmacy, but in reality, the order was never placed, and the resident went without the memantine for over a week.

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;

Vulnerable Adult interviewed: No, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility contacted the family member after discovering the medication error and had her deliver his medication. The facility completed an internal investigation, assessed the resident and notified the physician.

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
	21387	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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 May 14, 2025, the Minnesota Department of Health initiated an investigation of complaint HL213872043M/HL213873449C and HL213871903M/HL213873194C. Violations were found for HL213871903M/HL213873194C but not issued due to open survey #SL21387016-0 No correction orders are issued for HL213872043M/HL213873449C and HL213871903M/HL213873194C.	0 000		