Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL298396642M
Compliance #: HL298395825C

Date Concluded: December 31, 2025

Name, Address, and County of Licensee Investigated:
North Star Assisted Living
400 South McKinley Street
Warren, MN 56762
Marshall County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 when a physician's order as prescribed for daily weight monitoring was entered incorrectly. As a result, the primary care provider (PCP) was not notified of a weight gain, resulting in the resident being hospitalized for pulmonary edema.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although a transcription error occurred and did not include the complete instructions for monitoring the resident's weights, the error was an isolated incident. Additionally, when the resident had a change in her overall condition, the facility responded appropriately by transferring her to the hospital. The resident received treatment and returned to her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider. The

investigation included review of the resident record, hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (CHF) venous insufficiency, and chronic obstructive pulmonary disease. The resident's service plan included assistance with daily weights. The resident's assessment indicated the resident had edema and took medications to help with fluid retention.

A concern arose when it was found an order to monitor the resident's weights was not entered correctly. The order indicated the resident should be weighed daily and the medical provider should be updated with any weight gain of 3 pounds in a day and/or 5 pounds in a week. The order was entered as to notify the nurse if there was a weight gain of 3 pounds. This led to the facility not updating the resident's medical provider as planned. About a month after the error occurred, the resident was hospitalized and required treatment for CHF.

The medical records indicated over the course of approximately two months the resident's weights fluctuated up and down. The facility staff obtained the resident's weight daily, however, did not consistently report weight changes to the nurse.

Hospital records indicated the resident's weight was 197 pounds upon admission. Hospital notes indicated the resident had gained approximately seven pounds in the last four days and "appears to be quite volume overloaded today." The resident was admitted for heart failure exacerbation. When the resident returned to the facility, her weight was recorded to be 165.4 pounds.

During an interview, unlicensed personnel (ULP) #1 stated staff were instructed to check the resident's weight at a certain time every day. Staff were to record the weight in charting system and if the weight were at a certain point they would send a message to the nurse to let them know. ULP #1 stated the order was not clear but did not think anyone had contacted the nurse to clarify the order. ULP#1 stated she thought staff updated the nurse on any weight gains via a messaging system within their electronic medical record but were not sure if all out of range weights were reported.

During an interview, ULP #2 stated the resident started to swell in her fingers and when they offered to have her go to the clinic to be seen the resident refused. ULP#2 stated staff obtained weights at the same time every day.

During an interview, ULP #3 stated the facility nurse informed staff the resident had congestive heart failure and that her weight can fluctuate which can be a sign of her retaining fluid and that retaining fluid was hard on the resident's heart.

During an interview, management stated the nurse should have been getting automated alerts to the electronic medical record dashboard if staff had not sent an update on a weight change. Management stated the process for notifying the nurse and herself so two people would be updated, however she did not recall seeing any messages regarding the resident's weight.

During an interview, the nurse stated she was not aware the order had been entered incorrectly. The nurse stated she had never told staff to not update her on things and she would have expected the staff to update her of any weight gains. The nurse stated she could not recall if there were updates to the PCP, but staff should have been updating her on a significant increase. The nurse stated she had requested the facility add a process for double checking orders and it had been difficult to get that implemented.

The resident's PCP stated the clinic did receive an update on the resident's weights or changes in symptoms came from a home health provider shortly before the resident was hospitalized. The PCP stated the resident did have weight gain and the facility did miss providing updates on the resident's weight. However, the PCP had seen the resident throughout the month, offered in-clinic visits, and had not observed respiratory distress.

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.
(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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility investigated the incident and changed its process for monitoring daily weights and updating the PCP.

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
	29839	A. BUILDING: _____ B. WING _____	C 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH STAR ASSISTED LIVING	400 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 November 12, 2025, the Minnesota Department of Health conducted a complaint investigation HL298395825C/HL298396642M at the above provider. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	