Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302937882M
Compliance #: HL302933721C

Date Concluded: February 24, 2025

Name, Address, and County of Licensee Investigated:
Edgewood Baxter LLC
14211 Firewood Drive
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Erin Johnson-Crosby 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 resident was neglected when facility staff did not receive scheduled Cymbalta (antidepressant) medication, and the medication was not administered for several days. The resident was hospitalized due to the medication error.

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, facility staff contacted the resident's provider. The resident later returned to their 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 medical record, hospital records, facility internal investigation documentation, facility staff schedules,

and related facility policy and procedures. At the time of the onsite visit, the investigator observed medication administration and interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, major depressive disorder, and seasonal affective disorder. The resident's service plan included assistance with medication administration. The resident's assessment indicated was alert, and oriented. The resident utilized medication to manage depression per physician orders.

The resident's physician's orders included an order for Cymbalta (antidepressant) 120 milligrams daily.

Facility documentation indicated facility staff were questioned on when the resident last received prescribed Cymbalta as the resident was weepy and did not feel well. The investigation indicated a transcription error was discovered. The transcription error occurred within the electronic record system when the resident's Cymbalta order was merged with Doxycycline (antibiotic) which discontinued the Cymbalta order. As a result, the Cymbalta order did not appear on the medication record for staff to administer the medication and the resident did not receive Cymbalta for 11 days.

Review of the resident's medical record and hospital records indicated that in the eleven days the resident did not receive his prescribed Cymbalta medication, the resident was hospitalized twice, and hospital records did not identify the Cymbalta order was missing or discontinued. Two days after the transcription error occurred the resident was hospitalized for low blood pressure, severe anemia, and respiratory symptoms. The hospital discharge orders did not include Cymbalta. Five days later, the resident was seen in the emergency room for weakness, anxiety attack, and upper respiratory infection. The emergency room discharge orders did not include Cymbalta.

During an interview, the registered nurse (RN) indicated after the medication error was discovered, she immediately assessed the resident and contacted the resident's medical provider to obtain a new order for Cymbalta. The medication was re-started that day. The RN stated the facility completed re-education for staff.

During an interview, the resident stated she had been on Cymbalta for years for depression. The resident stated she "felt horrible," and did not know what was wrong with her. The resident stated she felt much better since Cymbalta was re-started.

During an interview, the resident's family member stated the resident's mood had improved since the Cymbalta was re-started; however, she was concerned the same issue could happen to another resident.

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: Not Applicable

Action taken by facility:
An internal investigation was initiated, and education was provided.

Action taken by the Minnesota Department of Health:

The facility was found to be in 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

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

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
	30293	A. BUILDING: _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BAXTER LLC	14211 FIREWOOD DRIVE BAXTER, MN 56425

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL302933721C/#HL302937882M On January 9, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL302933721C/#HL302937882M, tag identification 1760, 2480.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of one residents (R1) with records reviewed. The licensee also failed to ensure a system was in place to identify, document, track, and evaluate medication errors which had the ability to affect all residents who recieved medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	01760	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	

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01760	Continued From page 2 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on June 2, 2018, with current diagnoses including congestive heart failure, major depressive disorder, and seasonal affective disorder. R1's assessment dated December 5, 2024, indicated R1 was alert and oriented. R1 had a depression diagnosis and utilized medication to manage symptoms per physician orders. R1's service plan dated September 4, 2024, indicated R1 required assistance with medication administration. R1's physician visit notes dated November 20, 2024, indicated current physician orders included duloxetine (Cymbalta) an antidepressant, 60 milligrams (mg), take two capsules by mouth once daily, the Cymbalta had an order end date of December 4, 2024. Fiber-lax 625 mg, take two capsules by mouth three times daily for constipation, calcium citrate-vitamin D 315-200 mg-unit take one tablet by mouth twice daily for vitamin deficiency. R1's December medication administration record (MAR) indicated Cymbalta was not administered December 2 through December 12, 2024. R1 did not receive Cymbalta for 11 days. The December 2024 MAR also indicated R1 did not receive 10 doses of calcium citrate-vitamin D3, and did not receive 13 doses of Fiber-lax due to the medications not being available from the pharmacy. R1's MAR indicated Cymbalta had an	01760	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.	

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01760	Continued From page 3 end date of December 3, 2024 at 12:14 p.m. R1's medical record did not include medication error reports for the omitted medications. R1's progress note dated December 4, 2024, written on December 9, 2024, indicated R1 fell and was transferred to the hospital and admitted with diagnoses including hypotension (low blood pressure), severe anemia, and respiratory symptoms. R1 returned to the facility following hospitalization. R1's hospital discharge records did not identify concern of Cymbalta not being administered and did not identify Cymbalta on R1's list of medications. R1's progress notes dated December 10, 2024, R1's family member (FM)-B requested the nurse assess R1. R1 was crying and stated, "I'm so sorry, I don't feel good and don't know what's wrong with me." FM-B transported the resident to the emergency room. R1 was seen in the emergency room for weakness, anxiety attack, and upper respiratory infection. Hospital records did not indicate awareness of the missed Cymbalta and Cymbalta was not listed on the return list of medications on the hospital records. R1's progress notes dated December 13, 2024, indicated R1 had not received Cymbalta since December 2, 2024. R1 was tearful and emotional and stated, "I don't know why I am feeling this way." Facility staff found Cymbalta somehow dropped off the electronic MAR. R1's physician was notified. R1's physician visit dated January 8, 2025, indicated R1 was seen on December 10, 2024, for weakness, anxiety attack, and upper respiratory infection. R1's family member (FM)-B	01760		

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01760	Continued From page 4 reported she discovered Cymbalta was not on the facility list in late November. The chart review showed Cymbalta was not on the hospital discharge orders on December 5, 2024. FM-B messaged the provider on December 13, regarding the medication and a new script for Cymbalta was sent. R1's mood was better since re-starting Cymbalta. The licensee's internal investigation indicated on December 13, 2024, FM-B approached nursing staff and asked when the last time R1 received her prescribed Cymbalta, as R1 was weepy and did not feel well. The investigation indicated there was a transcription error that occurred on December 2, 2024, when Cymbalta was merged with Doxycycline (antibiotic) which discontinued the Cymbalta order. The medication was found in the medication cart. The internal investigation did not include interviews with the licensed or unlicensed staff regarding the error or investigation into the error. Email correspondence on January 15, 2024 with Rtask (electronic record system) support first indicated the Cymbalta was discontinued when it was merged with Doxycycline. Another email dated January 17, 2024, from Rtasks indicated an end date was manually entered for Cymbalta and was not related to merging medications. On January 9, 2025, at 1:04 p.m., FM-B stated when Cymbalta was abruptly discontinued, R1 was crying, shaking, hysterical, slumped over, and did not feel well. FM-B stated she was informed a medication was merged with an incorrect medication causing Cymbalta to be discontinued. FM-B stated during the time R1 did not recieve Cymbalta FM-B stayed with R1 for two nights due to R1's decline. FM-B stated she was concerned the same issue could happen to	01760		

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01760	Continued From page 5 other residents. R1 stated during this time she, "felt horrible," and did not know what was wrong. R1 stated she felt like she was losing her mind. R1 stated she did question staff administering her medications multiple times regarding her cymbalta not being administered. On January 9, 2025, at 12: 20 p.m., registered nurse (RN)-A stated on December 13, 2024, FM-B questioned if R1 was receiving her ordered Cymbalta as R1 was weepy, and not feeling well. The investigations indicated Cymbalta had not been administered since December 2, 2024. Cymbalta was not listed on the MAR but was in the medication cart. RN-A stated she did not complete a medication error report but should have. RN-A acknowledged following this incident all resident's medications were not checked for omitted medications due to transcription errors. On January 17, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-F stated a medication error report should have been completed. CNS-F stated after the medication error, licensed staff were now required to have two staff verify new orders. CNS-F acknowledged double verification of new orders could not prevent licensed staff from merging medications causing a medication to be discontinued. CNS-F stated if medications were omitted due to the pharmacy not delivering, she did not consider it a medication errors but the provider should be notified and documented in the resident's electronic medical record. CNS-F was not aware R1 missed multiple doses of calcium/vitamin D and Fiber-lax. CNS-F stated medication administration policies should be followed. The licensee's undated Medication Error policy indicated if a medication error occurs, staff will	01760		

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01760	Continued From page 6 document, track, and resolve medications administration errors for quality improvement. The licensee's Medication System Summary dated July 2024, indicated the licensee should establish supply/order systems to make resident medications available when needed and document and notify appropriate personnel when medication is unavailable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of two of two residents (R2, R3). In addition, the licensee failed to have a process in place to respond to and resolve resident grievances. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02480		

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02480	Continued From page 7 or has the potential to affect a large portion or all of the residents). The findings include: A complaint investigation was initiated at the licensee on January 9, 2025. During record review on January 9, 2025, grievances were requested for the last three months. A grievance dated October 7, 2024, indicated R2 had concerns regarding behaviors being added to his service plan due to being rude regarding a disgagreement about storing bird feed. R2 also had concerns about missing laundry, missing coumadin medication, and nursing communication. The grievance did not include a response or resolution. An undated grievance indicated R3 was admitted to a nursing home for physical therapy and was approved to return to the facility. The grievance indicated an assessment completed by a registered nurse included incorrect information which caused R3 to be unable to return to the facility. R3 requested another assessment be completed. Eleven days later another assessment was completed and R3 was able to return to the facility. The grievance indicated since inaccurate information was put in the original assessment it caused R3 to remain in the nursing home paying an extra $4,800.00. R3 requested a written response. The grievance did not include a response or resolution. On January 17, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-F stated all grievances went through the executive director and she was only	02480		

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02480	Continued From page 8 informed if the grievance included nursing concerns. CNS-F stated she did not know what the grievance policy included. CNS-F acknowledged there was no documentation related to the responses and resolutions for R2 and R3's grievances. On January 17, 2025, at 10:00 a.m., licensed assisted living director (LALD)- E stated responses and resolutions for grievances were not documented but should have been. LALD-E stated the grievance policy should have been followed. The licensee's Resident Complaint/Grievance Resolution policy dated March 2023, indicated Edgewood Management Group (EMG) will take all necessary actions to resolve a complaint or grievance that a resident and or resident representative has reported. Communication is the key in these types of situations and needs to be implemented immediately to resolve conflicts in a timely fashion." The policy listed steps that would be taken if a complaint or grievance could not be easily resolved or had not been resolved to a resident's satisfaction which included voicing concerns to Edgewood Management Group, directing concerns to the executive director or clinical services director, or the resident council. Responses to concerns would be given verbally unless requested in writing. The policy noted "Complex problems may require time to resolve and some problems may not be able to be resolved. Whatever the case, residents will be given a reasonable explanation for the action taken on their behalf. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02480		

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