Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302939822M
Compliance #: HL302934322C

Date Concluded: April 20, 2026

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

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

Evaluator's Name: Lena Gangestad, 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 the resident was prescribed a titrating dose of Mounjaro but received a higher dose than ordered during the 5 mg phase, resulting in medication errors on two occasions.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although the medical error happened, the error was an isolated incident. The resident was sent to the hospital due to nausea, vomiting, and weakness, and returned to the facility two days later at their baseline health condition.

The investigator conducted interviews with facility administrative staff and family member. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses type two diabetes. The resident's service plan included assistance with medication administration.

According to the medication administration record, the resident was prescribed a titrating dose of Mounjaro: 2.5 milligrams subcutaneously weekly for four doses, then 5 milligrams subcutaneously weekly for four doses, followed by 7.5 milligrams weekly for four doses.

A concern arose when the resident was sent to the hospital due to nausea, vomiting, and weakness. During her hospitalization, the hospital discovered the medication error.

During an interview, a family member said the resident received an incorrect dose of Mounjaro. Instead of gradually increasing the dose as prescribed, it was increased from 2.5 milligrams to 7.5 milligrams. The family member stated the resident was hospitalized for two days and went back to her baseline. She said she had no concerns regarding the overall care provided to the resident.

During an interview, a manager stated the resident was scheduled to receive 2.5 milligrams weekly for four doses, followed by 5 milligrams weekly for four doses, and then 7.5 milligrams weekly. The manager said a staff member notified her one day that the 5 milligram dose was unavailable. While attempting to manage the situation using two applications on her phone, she mistakenly believed the resident had completed the 5 milligram phase and initiated the 7.5 milligram dose prematurely. As a result, the resident received incorrect doses on two separate occasions. The manager further stated a few days later, the resident was admitted to the hospital due to nausea, vomiting, weakness, and cardiac concerns. The family contacted the facility regarding suspected incorrect dosing. Upon confirmation, the manager contacted the primary care provider and the pharmacy. It was then discovered that the pharmacy had not shipped the 5 milligram dosage and could not provide an explanation. Upon the resident’s return to the facility, the provider reassessed the resident and adjusted the medication regimen. The facility also implemented a corrective measure requiring the pharmacy to dispense medications in accordance with the prescribed schedule, rather than supplying all doses at once.

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: No.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: Upon the resident’s return to the facility, the provider reassessed the resident and adjusted the medication regimen. The facility also implemented a corrective measure requiring the pharmacy to dispense medications in accordance with the prescribed schedule, rather than supplying all doses at once. The facility retrained all caregivers on this topic.

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
	30293	A. BUILDING: _____ B. WING _____	C 03/03/2026

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

(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 March 3, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL302939822M/HL302934322C. No correction orders are issued.	0 000		