Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304251200M
Compliance #: HL304255361C

Date Concluded: April 20, 2026

Name, Address, and County of Licensee Investigated:
Ecumen Pathstone Crossing
708 Mound Ave 5214
Mankato, MN 56001
Blue Earth 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 a staff member discovered medications at the resident's bedside that had not been taken as prescribed. The medications found included three Metoprolol ER 50 mg tablets and two Aspirin 81 mg tablets.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although a medication error occurred, it was an isolated incident. On the same day the error was discovered, the resident experienced a fall and was sent to the hospital for further evaluation. The resident was admitted due to atrial fibrillation. Therefore, it is unclear whether the hospitalization was related to the medication error or the resident's underlying medical condition. The resident returned to the facility three days later and returned to her baseline health condition.

The investigator conducted interviews with administrative staff. 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 included cardiac dysrhythmia. The resident's service plan included assistance with medication administration.

A concern arose when a staff member discovered medications at the resident's bedside that had not been taken as prescribed. The medications found included three Metoprolol ER 50 mg tablets and two Aspirin 81 mg tablets.

According to the medication administration record, all the medications were administrated as prescribed.

During an interview, the manager stated a staff member reported the incident to her. She said she spoke with the resident, who indicated she did not want to take the medications because they appeared unusual. The manager further stated she educated the resident the pharmacy may occasionally change suppliers, which can cause medications to look different, however they are the same medications. She encouraged the resident to ask questions and to take medications as prescribed. The manager also said later the same day, the resident tripped over a box and fell. The resident was subsequently sent to the hospital due to back pain and was admitted in relation to atrial fibrillation. Following the incident, an internal investigation was initiated, and staff were educated on ensuring residents take their medications as prescribed.

During an interview, the resident stated she did not remember the incident and had no concerns regarding the care she received.

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: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility initiated an internal investigation. The resident was sent to the hospital for further evaluation. All staffs were re-educated on medication administration, and the care plan was updated.

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
	30425	A. BUILDING: _____ B. WING _____	C 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHSTONE CROSSING	718 MOUND AVENUE MANKATO, MN 56001

(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 February 19, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL304251200M/HL304255361C and #HL304258103C. No correction orders are issued.	0 000		