Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306886202M
Compliance #: HL306884700C

Date Concluded: November 26, 2025

Name, Address, and County of Licensee Investigated:
Epiphany Senior Living
10955 Hanson Blvd
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Substantiated, facility responsibility

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 did not receive his coumadin (a medication that thins the blood), for multiple weeks resulting in a hospitalization and death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff entered the resident's coumadin on the resident's electronic medication administration record (EMAR), then discontinued the coumadin order. The coumadin was sent to the facility by the pharmacy but was discontinued by facility staff and not administered to the resident. The resident missed three weeks of coumadin then had a change in condition, was hospitalized and died.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident's hospital physician. The investigation included review of the resident record(s), death record, hospital records, pharmacy records,

facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed the facility physical plant, medication administration, treatment administration and care being provided with staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis, paraplegia, history of pneumonia and stroke. The resident's service plan included assistance with medication management and provider ordered laboratory tests. The resident's assessment indicated the resident was orient to person, place, time and situation. The assessment indicated the resident received assistance with coumadin therapy, including as needed provider ordered laboratory tests, weekly International Normalized Ratio, (INR) monitoring, (a blood draw that indicated how quickly the blood clots) and medication management.

Medical records indicated facility nurse #1 obtained the resident's INR results and updated the resident's provider, who prescribed a new coumadin order. Facility nurse #1 faxed the new coumadin order to the pharmacy. Facility nurse #1 discontinued the order while attempting to update the EMAR. The pharmacy obtained the resident's new coumadin order, dispensed, and delivered the medication the same day it was prescribed. The medication was placed in the medication cart but not administered.

Medical records indicated three weeks later, facility nurses #2 and #3 received the resident's new INR laboratory results which were 1.1 (therapeutic range was between 2-3). After reviewing the resident's EMAR, the nurses discovered the resident's previous coumadin order was not listed on the document. The nurses updated the resident's provider and family regarding the incident. The resident's provider ordered the resident's coumadin be restarted and a new INR laboratory test be completed in approximately 2 days. A few days after the coumadin medication was resumed an agency nurse arrived to obtain the INR blood work. The agency nurse found the resident was lethargic, disoriented, and had a fever. The agency nurse updated the facility nurses and the resident's family. The resident was transported to the hospital.

Hospital records indicated the resident was admitted with altered mental status. An exam indicated the resident had right sided weakness. The resident's INR results obtained in the hospital was 1.2. The resident was diagnosed with a stroke and had frequent seizures requiring admission into the intensive care unit. The resident was intubated and was diagnosed with pneumonia related to the ventilator. The resident died approximately two weeks later.
The resident's death record indicated the resident died from acute ischemic stroke (occurs when blood flow to a part of the brain is blocked, usually by a blood clot, leading to brain cell damage or death).

During an interview, facility nurse #1 stated she recalled receiving the resident's INR results and updated the resident's provider. A new order was obtained from the provider, and the order

was faxed to the pharmacy. Facility nurse #1 stated she attempted to enter the order into the resident's EMAR and discontinue the previous coumadin order. Facility nurse #1 stated she thought facility management would review the order later that day however it was not reviewed.

During an interview, facility nurses #2 and #3 stated they were alerted to the incident after the resident's new INR results were received and neither nurse could find a coumadin order on the resident's EMAR. The resident's coumadin order was faxed to the pharmacy and discontinued in the EMAR a few weeks prior. The resident's family and the medical provider were updated. Facility nurse #2 and #3 stated the resident's order for coumadin was reinstated and another INR was ordered for the following day. The resident was not assessed after the coumadin error was found.

During an interview, facility management stated facility nurse #1 started the resident's new coumadin order but then discontinued the same coumadin order on the same day. Facility nurse #1 informed facility management she did not know how the coumadin order was discontinued and did not realize what had occurred. Facility management stated when the medication was delivered there was no documentation who received the medication, and no medication reconciliation occurred.

During an interview, the physician stated the resident was supposed to be on lifelong coumadin. The resident's INR was subtherapeutic (when a person's blood is clotting faster than the desired rate for their condition) upon admission which led to the resident's stroke, subsequent seizures, the need for a ventilator for which the resident acquired pneumonia. The cause of the cascade effect was from the stroke that was initiated by the subtherapeutic INR results.

During an interview, the resident's pharmacy obtained, dispensed and delivered the resident's Coumadin to the facility.

During an interview, a family member stated the facility staff were administering the medication ordered by the provider to the resident. A facility nurse reported the resident did not receive coumadin for several weeks.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

Action taken by facility:
The facility completed a facility investigation of the incident.
The facility sent the resident to the hospital after a change in condition was reported.
The facility educated nursing staff on Coumadin orders and INR facility processes.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30688	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY ASSISTED LIVING LLC	10955 HANSON BOULEVARD NW COON RAPIDS, MN 55433

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, 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: #HL306884700C/#HL306886202M On November 4, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306884700C/#HL306886202M, tag identification: 2360.	0 000	Assisted Living Provider 144G. 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.	

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02360	Continued From page 1	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360		