Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307647742M
Compliance #: HL307643263C

Date Concluded: March 28, 2025

Name, Address, and County of Licensee Investigated:
The Lodges Company
27890 Natchez Avenue
Elko New Market, MN 55020
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger, RN BSN
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 oxygen was not administered the resident causing hospitalization.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although the resident's oxygen tubing was not connected to the tank when emergency medical services (EMS) arrived, it was unclear how or when that occurred. However, the facility identified the resident's overall change in condition and sought emergency care appropriately.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff members providing care to residents during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included congestive obstructive pulmonary disease (COPD), congestive heart failure (the heart cannot pump enough blood for the body's needs) and multiple mental health diagnoses. The resident's service plan included assistance with medication management and administration, monitoring of self-harm, and reminders to complete personal hygiene. The resident's assessment indicated the resident was independent with health and financial decisions, had a history of refusing medications, treatments and self-hygiene cares. Additionally, it noted that the resident was a chronic smoker.

A concern arose when the resident's oxygen tubing was not connected to the oxygen tank and the resident had a low oxygen level.

The resident's medical record indicated the resident was at baseline throughout shift until the resident was reported to be convulsing and not responsive by a facility unlicensed caregiver. The resident had been attempting to move from a chair but was unable to do so safely. EMS was called and the resident was transferred to the hospital where she was admitted ultimately to the intensive care unit. Hospital records indicated the resident was hospitalized for aspiration pneumonia.

During an interview, the unlicensed caregiver stated the resident began acting differently between for approximately an hour before EMS was called. The unlicensed caregiver stated the resident normally takes her oxygen off and goes outside to smoke every half hour or so when awake. When the resident did not go outside, the unlicensed caregiver checked on the resident and noticed the resident was shaking. The unlicensed caregiver asked the resident if she wanted to have EMS called and the resident refused. The unlicensed caregiver stated the resident was then fine for a while but began shaking and became unresponsive again. The unlicensed caregiver was able to rouse the resident and offered to call EMS, which the resident agreed. The unlicensed caregiver stated she checked the resident's oxygen, and the oxygen was on the resident during the time preceding EMS' arrival.

During the same interview the unlicensed caregiver stated the resident's oxygen does frequently become disconnected from the oxygen tank or the resident fails to have the tubing placed properly in her nose.

During an interview, the resident stated she removes her oxygen to smoke, and the tubing has become disconnected at times from the oxygen tank if bumped. The resident went on to state the facility caregivers help her to keep an eye on her oxygen to make sure it is connected to her oxygen tank.

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.
(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: Not Applicable
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: No further action taken at this time.

Action taken by the Minnesota Department of Health: No further action 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
	30764	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON NATCHEZ	27890 NATCHEZ AVE ELKO, MN 55020

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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: #HL307649863C/#HL307646582M and HL307643263C/HL307647742M On February 25, 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 6 residents receiving services under the provider's Assisted Living license. No correction orders are issued for HL307643263C/HL307647742M. However, the following correction orders are issued for #HL307649863C/#HL307646582M: correction order identifications 1760 and 2360.	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.	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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 interview, and record review, the licensee failed to document the reason medications were not given as prescribed and to document follow-up procedures to ensure the resident's needs were met for one of one (R1) resident reviewed. The licensee also failed to ensure a system was in place to identify, document, track, and evaluate medication errors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the facility on August 25, 2020, with a diagnosis that included insulin dependent	01760		

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01760	Continued From page 2 type 2 diabetes. R1's care plan dated February 5, 2025, indicated R1 required assistance with medication management and administration and blood glucose monitoring. R1's October EMAR indicated the licensee was to administer the following medications: Humulin R (short-acting insulin) inject 100 units three times daily Basaglar (long-acting insulin) inject 30 units twice daily Ozempic (a medication to lower blood sugar) 1 mg injected weekly The EMAR dated October 14 indicated R1's evening Basaglar dose was not given due to lack of needles to administer medication. The EMAR dated October 15 indicated R1's weekly Ozempic dose, Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 16 indicated R1's Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 17 indicated R1's Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 18 indicated R1's Humulin R doses to be given with meals and	01760		

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01760	Continued From page 3 Basaglar twice daily doses were not given due to needles not available to administer medication. The progress notes dated October 18, 2025, 7:34 p.m., indicated R1 was taken to the hospital for hyperglycemia. The same documented indicated this was treated and he returned to the facility the same day. The EMAR dated October 19 indicated R1's Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 20 indicated R1's Humulin R am dose and morning dose of Basaglar were not given due to needles not available to administer medication, the evening dose of Basaglar was initialed as administered to R1. The afternoon and evening doses of Humulin R indicated R1 was out of the facility. The EMAR dated October 21 indicated R1 was out of the facility for morning doses of Humulin R and Basaglar. The progress notes electronically signed on October 22, 2024, at 5:49 p.m., but dated for October 17, 2024, at 10:57 a.m., indicated R1 was out of supplies "non-wearable" diabetic supplies. The same document indicated the facility asked the medical provider to send a request to the local pharmacy. A review of the document did not specifically mention insulin pen needles for administration. The progress notes electronically signed on October 22, 2024, at 5:57 p.m., but dated for October 19, 2024, at 5:49 p.m., indicated the	01760		

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01760	Continued From page 4 local pharmacy could not fill order for test strips. A review of the document did not specifically mention insulin pen needles for administration. The progress notes electronically signed on October 22, 2024, at 6:01 p.m., but dated for October 20, 2024, at 5:58 p.m. indicated the facility attempted to purchase pen needles on October 19 unsuccessfully. The facility contacted their contracted pharmacy requesting pen needles for insulin administration be delivered ASAP. A review of the medical records for dates of October 19-21, 2024, did not identify documentation indicating the facility contacted the medical provider for an order for the pen needles. The progress notes electronically signed on October 22, 2024, at 6:05 p.m., but dated for October 21, 2024, at 12:02 p.m. indicated R1 was hospitalized on October 20, 2024, and was discharged back to facility with pen needles when he returned to the facility on October 21. The progress notes dated October 22, 2024, at 6:05 p.m. indicated R1 was again transferred to hospital for hyperglycemia. The progress notes on October 22, 2024, at 6:50 p.m. indicated the RN was updated on October 19, 2024, of the need to obtain insulin pen needles for R1. The resident returned to the facility on October 24, 2024. The facilities medication error report log did not contain medication error reports for R1 in October containing corresponding dates for medications	01760		

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01760	Continued From page 5 that were not administered. A review of R1's medical record did not indicate the medical provider was notified of missed medication doses in October. The EMAR dated November 12 indicated Ozempic dose was not administered and out of stock, nurse notified. A review of R1 progress notes for November did not indicate documentation regarding the missed dose. A review of R1's medical record for November did not indicate the medical provider was notified of missed medication doses. The facilities medication error report log did not contain a medication error report for R1 in November containing corresponding date for medications that were not administered. The EMAR dated December 3 indicated R1's weekly Ozempic dose was not given, medication was out of stock. The EMAR dated December 17 indicated R1's weekly Ozempic dose and evening meal dose of Humulin R was not given, medication was out of stock. The EMAR dated December 18 indicated R1's Humulin R noon and evening meal doses were not given as medication was out of stock. A pharmacy delivery record dated December 18 at 8:25 p.m. indicated R1's Humulin R was delivered.	01760		

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01760	Continued From page 6 The EMAR dated December 24 indicated R1's weekly Ozempic dose was not given, resident refused medication. The EMAR dated December 31 indicated R1's weekly Ozempic dose was not given, medication was out of stock. A review of R1 progress notes in December did not indicate documentation regarding the missed doses. A review of R1's medical record did not indicate the medical provider was notified of missed medication doses. The facilities medication error report log did not contain medication error reports for R1 in December containing corresponding dates for medications that were not administered. The EMAR dated January 7 indicated R1's weekly Ozempic doses were not given and out of stock with nurse notification. The progress notes dated January 13 indicated R1 had an Endocrinology appointment during which Ozempic dose was increased along with new orders to address high blood sugars. The same document indicated R1's Basaglar was discontinued. The EMAR dated January 14 indicated R1's weekly Ozempic doses were not given and out of stock with nurse notification. The EMAR dated January 21 indicated R1's weekly Ozempic doses were not given and out of stock with nurse notification.	01760		

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01760	Continued From page 7 The EMAR dated January 26 indicated R1's Humulin R doses, to be given with meals three times daily, were not given. Documentation indicated needles were not available to administer the medication. A pharmacy delivery record dated January 28 at 4:53 p.m. indicated R1's Ozempic dose was delivered. A pharmacy delivery record dated January 30 at 7:43 p.m. indicated R1's pen needles were delivered. A review of R1's progress notes did not include documentation regarding missed doses of Ozempic or Humulin R for January. A review of R1's medical record did not indicate the medical provider was notified of the January missed medication doses. The facilities medication error report log did not contain medication error reports for R1 in January containing corresponding dates for medications that were not administered. The EMAR dated February 15 indicated R1's Humulin R doses, to be given with meals three times daily, were not given as medication was out of stock and indicated nurse notification. The EMAR dated February 16 indicated R1's Humulin R doses, to be given with meals three times daily, were not given as medication was out of stock and indicated nurse notification. The EMAR dated February 17 indicated R1's Humulin R dose, to be given with the morning meal, was not given as medication was out of	01760		

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01760	Continued From page 8 stock and indicated nurse notification. A pharmacy delivery record dated February 17 at 11:00 a.m. indicated R1's Humulin R was delivered. A review of R1's progress notes did not include documentation regarding missed doses of Humulin R for February. A review of R1's medical record did not indicate the medical provider was notified of the February missed medication doses. The facilities medication error report log did not contain medication error reports for R1 in February containing corresponding dates for medications that were not administered. On March 13, 2025, at 2:45 p.m. during a phone interview, nurse-C stated she had been assigned to the resident shortly before the beginning of Month #1. Nurse-C stated the pharmacy dispensed insulin pens but did not dispense the insulin pen needles due to "state rules", however now the facility gets the needles from a different pharmacy. Regarding EMAR documentation, nurse-C stated the unlicensed caregivers passing medications use an "automated snippet" when a medication is not given as ordered, however the nurse is not necessarily notified. Nurse-C stated the facility does not complete audits of the facility's EMARs and she was not personally involved in medication error reports. The facility's policy and procedure titled "Medication and Supplies reordering" dated 9/23/2020, indicated the staff of The Lodges Company will assist residents to make sure medications and supplies are ordered and	01760		

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01760	Continued From page 9 available as needed. The facility's policy and procedure titled "Medication errors" dated 9/23/2020, indicated the staff of The Lodges will document, track and resolve medication administration errors for quality improvement and to follow proper procedures. The facility's policy and procedure titled "Insulin" dated 9/23/2020 indicated only properly trained staff of The Lodges Company may provide medication assistance or administration. Insulin medications must be administered according to the prescriber's orders. Time period for correction: Seven (7) days.	01760		
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	02360		

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02360	Continued From page 10 details.	02360		