Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307649983M
Compliance #: HL307641041C

Date Concluded: March 28, 2025

Name, Address, and County of Licensee Investigated:
The Lodge of Natchez
27890 Natchez Ave.
Elko New Market, MN 55020
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Deb Schillinger, RN BSN
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 continuous blood sugar monitoring (CGM) device was not changed as ordered.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to have orders, or a treatment plan for the resident's continuous glucose monitor present in the resident record.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the guardian. The investigation included review of the resident record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the facility environment and interactions between resident and facility staff during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes. The resident's service plan included medication management and administration, including insulin and monitoring blood sugar four times per day. The resident's assessment indicated the resident was able to make decisions regarding his care and required assistance with insulin injections and blood sugar monitoring.

A concern arose the resident was using a CGM, but the facility was not managing it in coordination with his diabetic regimen.

During an onsite visit, the investigator observed the resident with the CGM in place on his skin confirming it was in use.

A review of the medical record did not contain an order for CGM on the day of the onsite visit for this investigation. However, the facility did present an order the following day.

A review of the resident's service plan did not identify documentation of tasks to monitor, change or record data from the resident's CGM. The task list indicated an Accu-Chek (a blood sugar check) should be completed four times daily. However, when the completed service task list by the caregivers did not identify documentation of the blood sugar results.

During an interview, an unlicensed staff member stated the resident had been utilizing the CGM for approximately the last two years. The unlicensed caregiver stated the CGM meter alerted the unlicensed caregivers when the system needed changed. However, the unlicensed caregiver stated they did not document when the monitor was changed in the electronic medical record.

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: Yes

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: No action taken

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:
Office of Ombudsman for Long Term Care
Office of Ombudsman for Mental Health and Developmental Disabilities
Scott County Attorney
Elko New Market City Attorney
Elko New Market Police Department

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 03/18/2025

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

(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, 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: #HL307641041C/# HL307649983M On March 18, 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. The following correction order is issued/orders are issued for #HL307641041C/# HL307649983M, tag identification 1960 and 2360.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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01960	Continued From page 1 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement and document the treatment procedure of changing the blood glucose monitoring sensor for one of one resident (R1). 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 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 type 2 diabetes. R1's master care plan dated March 10, 2025, indicated R1 required assistance with medication management, administration and blood glucose monitoring. A review of R1's master care plan dated March 10, 2025, did not indicate a task related to monitoring, changing or documenting results of a	01960		

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01960	Continued From page 2 continuous glucose monitor (CGM). A physician order dated on March 19, 2025, at 11:53 a.m. indicated R1's CGM should be changed every 14 days. An interview with R1 on March 18, 2025, indicated a CGM in place to R1 right upper arm. R1 stated unlicensed caregivers decline to change the monitor and tell R1 they do not know how to change the CGM. On March 20, 2025, at 9:30 a.m. an email was received from the manager indicating a new policy and procedure for CGM management. The email indicated training would be initiated. On March 27, 2025, at 5:20 p.m., unlicensed caregiver-A stated training was provided on March 24, 2025 on CGM monitor. Caregiver-A stated R1 had been using the CGM since he started working in that facility in November 2024. The licensee's policy titled Continuous Glucose Monitor (CGM) dated 3/19/2025 indicated the necessary use, monitoring and documentation. The same document educates on emergency protocols and when to notify the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01960		
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	02360		

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02360	Continued From page 3 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.	02360		