Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308183123M
Compliance #: HL308185668C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Guardian Angels by the Lake
13439 185th Lane NW
Elk River, MN 55330
Sherburne County

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

Evaluator's Name:
Katherine Barnhardt 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 alleged perpetrator (AP), facility unlicensed personnel, neglected the resident when the AP administered an incorrect dose of Dilaudid, and the resident was hospitalized. Additionally, facility staff failed to notify family of a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP followed the electronic medication administration record and administered the correct dose of Dilaudid (opioid analgesic). Hospital records indicated the resident was admitted for deep vein thrombosis (blood clot) of the right leg and bilateral pulmonary embolisms (blood clots in the lungs). The administration of Dilaudid had no correlation on the resident's change in condition and hospitalization. Additionally, licensed staff notified family of a fall without injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a hospital and a rounding

provider. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff provide direct cares and medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, stroke, deep vein thrombosis and bilateral pulmonary embolism. The resident's service plan included medication administration and safety checks. The resident's assessment indicated right hip complications caused chronic pain and the resident was dependent on staff for ambulation and transfer assistance. The resident was at high risk for falls, had significant cognitive impairment and was impulsive.

The resident record indicated the resident had a significant decline in overall health during the few months prior to the emergency room visit and hospitalization. Licensed staff completed a comprehensive assessment one day prior to the resident's hospitalization and a cognitive decline was noted. A rounding provider visited the resident two days prior to the resident's change in medical condition and noted the changes in the resident's record. In addition, the rounding provider adjusted the resident's Dilaudid one week prior to the resident's hospitalization. One day unlicensed personnel found the resident in her apartment pale and unresponsive, notified licensed staff, and arranged for the resident to be evaluated at a hospital.

The investigator observed the resident's medication doses were pre-packaged by the pharmacy into single packages prepared according to time scheduled doses for administration.

Provider orders indicated the resident was prescribed hydromorphone (Dilaudid) 2 mg (milligram), take 0.5 tablet (1 mg) by mouth twice daily and every six hours as needed to start on Monday following a weekend. The same order indicated oxycodone (opioid analgesic) was discontinued.

The resident's narcotic log record indicated the AP administered the resident's Dilaudid as ordered prior to the resident's medical change. The narcotic log indicated the resident had not received any as needed doses prior to the 911 call.

Progress notes indicated unlicensed personnel contacted a licensed staff after they entered the resident's room and found the resident pale, clammy and unresponsive. Unlicensed personnel obtained vital signs and the resident's oxygen saturation level was 66% (normal level 95% to 100%). Licensed staff arranged for the resident to be evaluated at a hospital and progress notes indicated the family was notified.

Hospital records indicated the resident arrived at the emergency room with low oxygen, 88% on 1-2 liters per minute of supplemental oxygen. The resident appeared sedated and could not provide a history. Hospital staff contacted the facility, and it was initially reported the resident

received 2.5 milligrams of Dilaudid, however, later clarified with the AP the resident received 1 milligram as ordered. The resident's diagnoses included bilateral (both sides) pulmonary embolism (blood clots in the lungs) in addition to a deep vein thrombosis of the right lower extremity. Over time with oxygen and heparin (blood thinning medication) treatment the resident's mental status improved. The resident discharged to a rehabilitation facility and later returned to the facility.

During an interview, licensed staff stated medications from the pharmacy were prepackaged in dose scheduled packages. Licensed staff stated medication orders are sent to, verified and processed through a pharmacy before delivery to the facility then licensed staff reconcile delivered medications before unlicensed staff administer. Licensed staff stated unlicensed personnel are required to date and initial the medication packages as doses are administered. Licensed staff stated he had no knowledge of a medication error that resulted in a hospitalization of the resident. Licensed staff stated unlicensed staff completed incident reports for falls and licensed staff assess and investigate the cause of the fall. Licensed staff stated only licensed staff notify families when a fall occurs.

During an interview, a rounding provider stated the resident had a lot of functional and cognitive changes over a period prior to the hospitalization. The rounding provider stated family had received communication about hospital concerns in the emergency room that the resident had received 2.5 mg of Dilaudid instead of 1 mg and potentially unlicensed personnel had administered more than what the rounding provider had ordered. The rounding provider stated she did not feel that was accurate because there was no way for unlicensed personnel to administer more Dilaudid than was ordered the way the medication was packaged from pharmacy. The rounding provider stated pharmacy prepackaged and pre-dosed the resident's medication and the hospital staff had not clarified Dilaudid dosing or packaging with facility licensed staff or with the provider. The rounding provider stated she felt there was an error in communication between unlicensed staff and the hospital.

During an interview, the AP stated she assisted the resident the morning the resident was sent to the emergency room. The AP stated the resident had difficulty walking to the bathroom and appeared short of breath. The AP stated the resident closed her eyes and was barely speaking to the AP when they entered the bathroom. The AP checked vital signs and noted a low oxygen saturation level. The AP stated she called a second staff to assist, notified a licensed staff and was directed to call 911. The AP stated she followed the electronic medication record and administered medications as directed. The AP stated medications are prepackaged into doses according to a scheduled time and narcotics are individually packaged per tablet in a cardboard bubble pack organizer. The AP stated she popped one tablet out of the medication card as directed, documented the administration in the electronic medication record and signed out the narcotic from the narcotic logbook. The AP stated she spoke with the hospital staff and read off the instructions for Dilaudid from the resident's electronic medication record.

During an interview, a family member stated the resident had medical changes over the last few months and she was notified the resident was sent to the emergency room with low oxygen and not responding to staff. A family member stated the resident had a fall without injury during the night and the family member was concerned she had not been notified until the following afternoon. The family member stated interventions were put in place, a camera was added to the resident's room, and she felt facility staff understood the resident's needs better.

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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility called 911 for emergency services when the resident had a significant change in condition.

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
	30818	A. BUILDING: _____ B. WING _____	C 06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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 June 30, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL308183123M/#HL308185668C. No correction orders are issued.	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.	