

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308187067M
Compliance #: HL308186785C

Date Concluded: February 5, 2026

Name, Address, and County of Licensee

Investigated:

Guardian Angels by the Lake Assisted Living
and Memory Care
13439 185th Lane NW
Elk River, MN 56329
Sherburne County

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

Evaluator's Name:

Katherine Barnhardt RN, Special Investigator

Finding: Inconclusive

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 was administered inaccurate medications resulting in weight loss, change in condition and placed on hospice twelve days after the resident returned to the facility.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Facility licensed staff were provided with new orders via fax, in person and through a pharmacy's electronic medication order system. Although the medication transcription and administration errors occurred, the resident had advanced co-morbidities, a urinary tract infection and multiple recent medication changes, it could not be determined the error caused the change in condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a home care agency and mental health provider. The investigation included review of the resident record(s), hospital records,

hospice records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included posterior cortical atrophy dementia (rare dementia causes visual and spatial blindness) and anxiety. The resident's service plan included assistance with medication administration and orientation. The resident's assessment indicated a recent and rapid decline in the resident's health. The resident's assessment indicated the resident required a Hoyer (mechanical lift utilizing a body sling) two-person transfer, a manual wheelchair and feeding.

Hospital records indicated the resident was hospitalized for six weeks with anxiety, mood and dementia related behaviors and medications were changed. Hospital records indicated the resident was stabilized and was discharged back to the facility with new medication orders. Hospital discharge records indicated medication changes included Rexulti (antipsychotic), Lorazepam (anxiety), Cymbalta (antidepressant), Depakote sprinkles (mood stabilizer), gabapentin (pain and anxiety) and discontinuation of risperidone (antipsychotic alters brain chemicals). Hospital discharge records indicated signed refill orders, and a discharge medication list was sent to the facility.

Medical records indicated the resident returned to the facility from a six-week geriatric mental health hospital stay and had numerous medication changes. When the resident returned to the facility, she was lethargic and required assistance from two staff and a wheelchair and feeding assistance. Within approximately two days the facility suggested the resident enroll in hospice. Over the next twelve days the resident continued to decline, having several falls, refusing medications and refusing to eat. The facility notified the resident's provider who gave orders for hospice to evaluate and admit. The resident continued to decline, and medical records indicated the provider was updated and advised facility staff to encourage fluids, add dietary supplement drinks, obtain a urine culture sample (test for bladder/kidney infection) and have the resident seen at an emergency room if needed. The resident's lab tests were positive for urinary infection. The provider was updated on the results however the provider's office advised for the facility to call back later for treatment orders.

Hospice records indicated the resident was admitted to hospice and the resident's status stabilized when the resident received hospice services. Hospice records indicated hospice staff reconciled the resident's medications with the facility and providers.

During an interview, a facility nurse recommended the resident admit to hospice services when the resident had a rapid decline in health a short time after the resident returned to the facility. A facility nurse stated the new medication list was sent to a pharmacy two days before the resident returned, however, some of the medications needed signed orders and the facility made several attempts to obtain signed orders.

During an interview, facility management stated when a resident returned from a hospitalization, orders were faxed to pharmacy, and the pharmacy would enter the medications into an electronic medication system. Facility management stated if pharmacy took longer to enter a medication, a facility nurse could hand enter medication orders into a resident's medical record. Facility management stated medication information entered by pharmacy was reviewed and approved by pressing a button and the medication information would populate into the resident's medical records. Double entry of medications had happened, and the process was audited. The pharmacy had medications entered for the resident the day before she returned, and the day the resident returned a facility nurse reviewed medications and compared to the paper list faxed to pharmacy. Rexulti required prior authorization, was too expensive for the resident and was eventually discontinued and no monitoring for withdrawals were implemented. Facility management was not sure how the transcription errors occurred.

During an interview, a provider stated the resident was stable, calm, had a good appetite and was accepting cares and medications at discharge. A provider stated the medication regimen the resident discharged with was effective for the resident. A provider stated she was surprised at the resident's presentation during a video call because during the short term stay the resident had been walking around, eating and doing activities to the best of her abilities.

During an interview, a representative stated the resident was walking and speech was mumbled when the resident returned to the facility, however, the representative felt the resident may have been given medication for the ride to the facility. The representative stated she requested a medication list several times from the facility to compare to the discharge medication list she received from the mental health facility. The representative stated she suspected medication errors contributed to the resident's rapid health decline, however, was unable to confirm.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Unavailable

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility reached out to providers and pharmacy. The facility requested supportive services for the resident from outside agencies.

Action taken by the Minnesota Department of Health:

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30818	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2025
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NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGELS BY THE LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 13439 185TH LANE NW ELK RIVER, MN 55330
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL308187067M/#HL308186785C</p> <p>On November 19, 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 89 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL308187067M/#HL308186785C, tag identification 1760.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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01760	<p>Continued From page 1</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to reconcile the discharge medication list after 6 weeks stay in geri-psych. The failure to reconcile resulted in several transcription errors and medications were administered incorrectly for one of one residents (R1) who received medication management services.</p> <p>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).</p> <p>The findings include: R1's diagnoses included dementia and anxiety.</p> <p>R1's Service Plan dated October 27, 2025,</p>	01760		
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01760	<p>Continued From page 2</p> <p>indicated services to include medication administration.</p> <p>R1's medical record included hospital discharge prescriber orders dated and signed October 7, 2025, indicated to STOP: gabapentin 100 milligram (mg) 200 mg three times daily; and STOP: gabapentin 100 mg as needed every four hours. The hospital discharge orders indicated to start gabapentin 400 mg four times daily.</p> <p>R1's electronic medication administration record dated October 2025 indicated: Gabapentin 100 mg two capsules by mouth three times daily was administered at 8:00 a.m. on October 10, 11, 2025 administered at 1:00 p.m. on October 10, 11, 2025</p> <p>R1's medical record included hospital discharge prescriber orders dated and signed October 7, 2025, indicated to start lorazepam 0.25 mg twice daily at 1200 and 1700;</p> <p>R1's electronic medication administration record dated October 2025 indicated: Lorazepam 0.25 mg twice daily at 1200 and 1700 was not administered October 10, 2025, through October 31, 2025.</p> <p>R1's medical record included hospital discharge prescriber orders dated and signed October 7, 2025, indicated to STOP: risperdal (risperidone) 0.5 mg three times daily and - STOP: risperdal 0.5 mg as needed every four hours.</p> <p>R1's electronic medication administration record dated October 2025 indicated: Risperidone 0.5 mg three times daily:</p>	01760		

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01760	<p>Continued From page 3</p> <p>8:00 a.m. was administered October 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 2025. 1:00 p.m. was administered October 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 2025. 8:00 p.m. was administered October 9, 10, 13, 14, 15, 16, 17, 18, 19, 20, 21, 27, 28, 2025.</p> <p>Risperidone 0.5 mg one tab by mouth every four hours as needed (PRN): As needed was administered October 10, 12, 13, 16, 19, 2025.</p> <p>R1's medical record included hospital discharge prescriber orders dated and signed October 7, 2025, indicated to STOP: cymbalta 40 mg daily; start: cymbalta 90 mg daily at 1700.</p> <p>R1's electronic medication administration record dated October 2025 indicated: Cymbalta 30 mg daily at 1700: Was not administered October 9, 10, 11, 16, 24, 2025. Was administered October 12, 13, 14, 15, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 2025.</p> <p>R1's medical record included hospital discharge prescriber orders dated and signed October 7, 2025, indicated to stop: methotrexate sodium 2.5 mg every Tuesday, and start: methotrexate sodium 2.5 mg every Wednesday at 1600.</p> <p>R1's electronic medication administration record dated October 2025 indicated: Methotrexate Sodium 2.5 mg every Wednesday was administered every Tuesday October 14, 21, 28, 2025.</p> <p>On November 19, 2025, at 3:15 p.m., guardian (G)-B stated she requested a medication list several times from the facility to compare to the</p>	01760		

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01760	<p>Continued From page 4</p> <p>discharge medication list she received from the discharging provider when the resident's health rapidly declined, but the facility and home care agency refused to provide it. G-B stated she suspected medication errors and questioned licensed staff, however, was unable to confirm.</p> <p>On November 20, 2025, at 2:45 p.m., registered nurse (RN)-C stated when a resident returned from a hospitalization, orders were faxed to pharmacy and the pharmacy would enter the medications into an electronic medication system. Licensed staff stated if pharmacy took longer to enter a medication, a licensed staff could hand enter medication orders into a resident's electronic medication administration (EMAR) record. Licensed staff stated medication information entered by pharmacy was reviewed and approved by pressing a button and the medication information would populate into the resident's EMAR. Licensed staff stated double entry of medications does happen and the process is audited. Licensed staff stated pharmacy had medications entered for the resident the day before she returned and the day she returned licensed staff reviewed medications and compared to the paper list faxed to pharmacy. Licensed staff stated she did not have answers regarding the gabapentin, Cymbalta and risperidone errors.</p> <p>On November 21, 2025, at 2:00 p.m., certified nurse practitioner (CNP-E) stated a rexulti prior authorization was completed for the resident before discharge and if stopped abruptly the resident could experience a return of agitation, hallucinations, anxiety, paranoia and restlessness. CNP-E stated until the first antipsychotic is cleared from the resident's system adding a second could cause sedation</p>	01760		
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01760	<p>Continued From page 5</p> <p>and agitation. CNP-E stated she reduced gabapentin doses after discharge based on reported symptoms, however, was unaware of medication errors at the time new orders were requested.</p> <p>The licensee's Administration of medication, Treatment and Therapy by Unlicensed Personnel policy dated September 18, 2024, indicated the RN would communicate with unlicensed personnel about the individual needs of the resident prior to delegation of medication administration to unlicensed personnel.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01760		
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