Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL310686582M
Compliance #: HL310685702C

Date Concluded: January 8, 2026

Name, Address, and County of Licensee Investigated:
Marywood
915 Kenwood Avenue
Duluth, MN, 55805
Saint Louis County

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

Evaluator's Name: Angela Vatalaro, 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 facility neglected the resident when the facility failed to ensure the resident had adequate pain management. As a result, the resident experienced unmanageable pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While unlicensed personnel (ULP) had technical difficulty in how they viewed the resident's electronic medication administration record (eMAR) throughout a weekend, the eMAR was still accessible, and records indicated the ULPs' administered the resident's pain medication as ordered. In addition, as the resident's pain medication increased throughout the weekend, the facility implemented orders, and the resident received pain medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, facility internal investigation, narcotic and controlled medication records, hospice

orders, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's unit and staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, chronic pain, and anxiety. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident received hospice services.

The resident's records indicated during a four-day timeframe prior to the resident's death, the resident had multiple medication changes for pain. The resident also had multiple medication changes for anxiety/restlessness/terminal agitation. The records indicated facility and on-call nurses communicated with hospice services regarding the changes. Records indicated the resident's narcotic pain medication and controlled medication for anxiety/restlessness/terminal agitation both increased throughout this timeframe.

The resident's records indicated the facility implemented hospice orders.

The resident's eMAR indicated staff provided the resident pain medication and provided medication for the resident's anxiety/restlessness/terminal agitation throughout this time frame. The eMAR indicated as orders changed, the resident received the increased doses of both medications.

The resident's progress notes indicated multiple ULP called the on-call nurses regarding issues viewing the resident's eMAR with the resident medication changes. However, the resident's narcotic and controlled medication logs reviewed in comparison with the resident's eMAR indicated medications staff removed were administered to the resident.

The facility's internal investigation indicated ULP were able to view the medication orders in the resident's eMAR after logging out and relogging into the eMAR a different way.

During an interview, a nurse stated the resident was on hospice services, declined quickly and transitioned to the stage of dying. The nurse said the resident's pain medications changed frequently, and the resident had medications for pain and terminal restlessness.

During an interview, an ULP stated towards the end of the resident's life, the resident's medication doses increased and changed due to the resident feeling uncomfortable. Staff contacted and spoke with the on-call nurses throughout the weekend due to how the medications were showing up on the eMAR. The ULP stated staff were still able to access the eMAR just in a different way of logging in.

During an interview, leadership stated the facility had designated ULP staff administering narcotic and controlled medications. There were technical issues with how the resident's medication changes were not pulling up on the designated ULP eMAR flow sheet. However,

leadership stated the resident's eMAR was still accessible to the designated ULPs by logging into the system a different way. Leadership stated the designated ULP's knew how to access the eMAR using the different way because the resident's narcotic and controlled medications were administered. The facility implemented orders received for the medication changes. Leadership conducted an internal investigation and determined the resident missed one dose of pain medication during this timeframe.

Other allegations of concern included the resident's falls. Records indicated the facility nurses assessed and monitored the resident after falls. Hospice and the resident's provider were updated. During investigative interviews, leadership and a nurse both stated the facility added interventions to reduce fall risk.

Another concern identified was the facility failed to have a nurse physically present in the building during an identified weekend. The resident's records indicated unlicensed staff had access to an on-call nurse, contacted and spoke to the on-call nurse numerous times.

Another concern identified was a ULP fell asleep, and the resident did not receive any pain medication throughout shift. Prior to the resident's death and during the timeframe in question, records indicated one dose of the resident's pain medication was not administered. However, records indicated the resident received his next scheduled pain medication dose and ongoing doses after that. Leadership stated there was an occasion when one ULP did fall asleep while on break. Leadership stated during overnight shift there was a second ULP available on the adjoining unit as well as a float ULP. Review of schedules supported leadership's stated staffing model. Leadership stated staff were expected to be awake. The facility conducted an internal investigation, and the staff member involved received discipline.

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: No. The resident was deceased.

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

Action taken by facility:
When unlicensed staff members contacted the on-call nurse throughout the weekend, on-call nurses spoke to the staff members and provided instruction.

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
	31068	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

(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 December 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL310685702C/#HL310686582M. No correction orders are issued.	0 000		