DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315736942M
Compliance #: HL315736102C

Date Concluded: February 10, 2026

Name, Address, and County of Licensee Investigated:
Willows of Ramsey Hill
80 N. Mackubin Street
St. Paul, MN 55102
Ramsey County

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

Evaluator's Name: Michele Larson, 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):
Facility staff neglected a resident when they failed to administer a resident's scheduled narcotic pain (morphine) and antianxiety (lorazepam) medications according to the resident's medical provider's orders which caused a delay in the resident getting relief from his anxiety and pain symptoms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the facility delayed the processing of the resident's hospice provider's orders for scheduled morphine and lorazepam until 24 hours later, the facility still administered his as needed (prn) doses of lorazepam. It was uncertain if the resident experienced uncontrolled pain during the noted time frame.

The investigator conducted interviews with facility staff members, including nursing staff, unlicensed staff. The investigator contacted the resident's family member and hospice team. The resident's primary medical provider was interviewed. The investigation included review of the resident's facility record, death record, hospice record, mobile primary care provider's records, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions while onsite at the facility.

The resident resided in an assisted living memory care facility. The resident's diagnoses included Alzheimer's Disease. The resident's service plan included assistance with personal cares, feeding, toileting, and medication administration. The resident was oriented to person only and had difficulty communicating due to his Alzheimer's diagnosis. The resident used a wheelchair and a walker for mobility. The resident received hospice services from an outside hospice agency.

The resident's hospice record indicated the following orders were received from the resident's hospice provider as well as the resident's mobile medical provider through the resident's online portal communication system. New orders included discontinuing lorazepam 1 mg three times per day to 1 mg every four hours and start morphine 5 mg every four hours to be administered with lorazepam. The medications were to be dissolved together in a small amount of water and administered underneath the tongue (sublingually) using a syringe. Facility leadership questioned the orders to the resident's hospice nurse, expressing concern about the frequency and necessity of scheduled morphine. Leadership refused to process the hospice medical provider's orders stating they had 24 hours to implement the orders. The resident's hospice nurse updated the resident's hospice provider, hospice leadership, and the resident's family member informing them the hospice provider's orders were not implemented. The hospice nurse talked to facility staff encouraging them to continue to administer the resident's prn lorazepam and morphine.

The resident's hospice record indicated although facility staff administered the resident his prn morphine the resident still struggled and continued to be agitated and confused.

The resident's progress note indicated even though facility leadership continued to express concerns about the hospice orders they implemented and processed the hospice provider's orders the following afternoon and the resident began his scheduled lorazepam and morphine every four hours.

The following morning the resident's family member stated she supported the resident's hospice team recommendations and felt the resident required more medication than was administered based upon the family member and staff member's observations. The family member indicated they believed the resident was in pain but could not express his pain.

Review of the resident's medical record indicated the resident continued to have on and off agitation and screaming despite receiving his scheduled lorazepam and morphine every four

hours. Additional adjustments and increases were made to the resident's scheduled lorazepam and morphine.

Days later the resident died related to the progression of Alzheimer's disease.

When interviewed, an unlicensed staff member stated the resident started quickly going downhill during the last month of his life, stating the resident became more aggressive and appeared frustrated when he was unable to communicate his needs.

When interviewed, a licensed facility staff member stated although the resident had increased agitation he would still walk around and eat cookies. The licensed staff member stated the hospice nurse took the orders off her desk after she and facility leadership questioned the order for scheduled morphine every four hours. Facility licensed staff stated the next afternoon she asked the hospice nurse for an update on the resident's orders stating the hospice nurse stated the resident's new orders remained the same. Facility licensed staff stated she did not believe the resident was in pain and thought the resident's medications were scheduled too often.

When interviewed, leadership stated the resident appeared stable with no signs of anxiety or pain the day the new orders for scheduled morphine and lorazepam were provided to the facility stating the hospice nurse "ripped" the orders out of the licensed facility staff's hands stating they would consult with hospice leadership. Facility leadership stated the resident's scheduled morphine and lorazepam were administered to the resident the following day at 3:00 p.m.

When interviewed, the hospice nurse stated the resident continued to be anxious after the third day, stating the hospice medical provider made additional changes to the resident's morphine and lorazepam to get him comfortable, stating she hoped the facility realized the resident was actively dying and experienced terminal restlessness.

When interviewed, the resident's hospice medical provider stated the facility worked outside the scope of their practice when they refused to act on an order the resident's two medical providers signed off on, stating she would have expected the facility to let them know if they truly felt the orders were inappropriate. The resident's hospice medical provider stated hospice resident's often have unexpected changes in their condition, stating it was frustrating and out of their hands when a facility does not follow their orders which resulted in a delayed care for the resident. The resident's hospice medical provider stated, "Ultimately, we are all on the same team."

When interviewed, the resident's family member stated they were happy with the cares the resident received from both the facility and the hospice agency but stated she ultimately sided with the hospice agency. The resident's family member stated she did not appreciate being in the middle of the disagreement between the facility and the hospice agency. The family member stated the resident seemed to relax after the resident's scheduled morphine and

lorazepam were increased. The family member stated, “I think everybody was trying to do their best for him.”

In conclusion, the Minnesota Department of Health determined 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: Yes or explanatory comment
Family/Responsible Party interviewed: Yes or explanatory comment
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility implemented the hospice provider’s orders within 24 hours.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31573	A. BUILDING: ______ B. WING ______	C 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF RAMSEY HILL	**80 NORTH MACKUBIN STREET SAINT PAUL, MN 55102**

(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 November 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL315736102C/#HL315736942M. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE