Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319875743M
Compliance #: HL319873628C

Date Concluded: November 20, 2025

Name, Address, and County of Licensee Investigated:
Northern Lakes Senior Living
8186 Excelsior Road
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Barbara Axness, 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 it failed to administer medications as prescribed. The medication administration record (MAR) did not include instructions that a medication should not be crushed. Staff crushed the medication, resulting in the resident being admitted to the hospital with an acute kidney injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident took potassium, a medication that cannot be crushed. If the medication is crushed, it can impact absorption and cause high potassium levels. The RN failed to include instructions on the resident's medication administration record (MAR) that the medication was not to be crushed. The facility investigation determined unlicensed personnel (ULP) crushed at least 9 of 16 doses of the medications. The resident was hospitalized with hyperkalemia (high potassium) and an acute kidney injury. However, due to other comorbidities, it could not be determined if the potassium being crushed led to the resident's hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included kidney disease and congestive heart failure. The resident's service plan included assistance with activities of daily living and medication administration. The resident's assessment indicated the facility managed the resident's medications and her medications were to be crushed.

The resident moved into the facility eight days before she was hospitalized. The facility's internal investigation indicated after the resident was hospitalized for hyperkalemia, a RN noticed that all of the resident's medications were being crushed and she wondered if the potassium was being crushed as that may have had an effect on the resident's potassium level. The facility identified that 9 of 16 doses were likely crushed after interviewing staff. In reviewing the electronic medical record, the facility identified that "Do Not Crush" was not clicked on the medication, which would have alerted staff to not crush the medication. The facility determined staff did not review the medication card, which had a "Do Not Crush" sticker on it and that the RN failed to complete a full medication reconciliation for admission medications when it was entered into the medication administration record. The RN failed to check medications upon arrival from the pharmacy for warnings and indications.

Hospital records indicated the resident was seen in the urgent care clinic two days before she was hospitalized for complaints of nausea and retching. The resident's antibiotic for a urinary tract infection was discontinued and the resident returned to the facility.

Upon arrival to the emergency room two days later, the resident's potassium level was 7 (levels above 5 are considered high and can cause life-threatening heart problems, muscle weakness, or paralysis). The resident was diagnosed with an acute kidney injury and severe life-threatening hyperkalemia (high potassium). The resident was hospitalized for five days and discharged to a different facility.

Unlicensed personnel (ULP) who administered some of the doses of potassium to the resident were interviewed. The ULP stated they were not previously aware potassium could not be crushed and they did not recall seeing instructions on the MAR or on the medication card. One ULP stated she brought the medication to the resident's room and the resident said she wasn't able to swallow it and it had to be crushed so she and the resident's daughter crushed it with a spoon to make it easier for the resident to take.

During an interview, a facility RN stated after the resident was hospitalized, another facility nurse was meeting with staff at shift change and while talking with the ULP, it was discovered at

that point some staff were crushing the potassium. The RN stated the facility began investigating and determined the order was not written to include “do not crush” so it was not put on the MAR and staff did not catch it was not on the MAR. The RN stated the pharmacy had recently changed its labels and while the card had “do not crush” on it, it was written in a different spot and was very small and staff reported they had not seen that on there.

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

Action taken by facility:
The facility identified the medication error after the resident was hospitalized and investigated the incident. The facility reported the incident to MAARC and retrained staff on medication administration.

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
	31987	A. BUILDING: _____ B. WING _____	C 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LAKES SENIOR LIVING	8186 EXCELSIOR ROAD BAXTER, MN 56425

(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 September 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL319875743M/ #HL319873628C. No correction orders are issued.	0 000		