Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329382362M
Compliance #: HL329384207C

Date Concluded: August 22, 2025

Name, Address, and County of Licensee Investigated:
A Janesville Senior Living LLC
543 Oakwood Drive
Janesville MN, 56048
Waseca County

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

Evaluator's Name: Kris Detsch, 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 a resident when they failed to administer pain medications correctly. As a result, the resident required Narcan (medication used to reverse the effects of overdose) and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The staff members administered narcotic medication accurately according to the physician's order for administration. The facility responded timely when the resident fell and appropriately coordinated her medical care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers, a medical provider, and law enforcement. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules,

law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration, narcotic medication counts, meals, documentation systems, and staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, bipolar disorder (mood disorder), and anxiety. The resident's service plan included assistance with medication administration. The resident's nursing assessment indicated the resident communicated verbally but was forgetful and had poor decision-making ability. The nursing assessment indicated the resident had verbal outbursts and repetitive thoughts/statements and required psychotropic medications (medications used to treat mental health conditions). The nursing assessment indicated the resident was unable to administer her own medications due to memory loss.

Resident records indicated she went to the hospital for knee surgery and returned to the facility with a physician's order for her to take oxycodone (opioid pain medication). The physician's order for medication administration indicated the resident should take one or two tablets every four hours as needed for pain.

Progress notes indicated two days after she returned to the facility, a staff member found the resident lying on the floor in her bathroom. The progress notes indicated the resident walked without assistance which occurred multiple times after her arrival back to the facility. At the time of the fall, the residents knee bandage was bloody. The resident told staff she felt a "ripping" sensation and she could not bend her knee. The staff sent the resident to the hospital.

Hospital records indicated the resident required medical treatment for pneumonia and too much oxycodone. The records indicated physicians gave her two antibiotic medications to treat pneumonia and decreased the dose and frequency for oxycodone to one tablet every six hours as needed for pain. The resident returned to the facility two days later.

The narcotic book indicated staff members verified the narcotic medication tablets during each removal of the medication and two staff members signed (initial) their name inside the book when they removed a tablet to verify the accuracy of the medication. The facilities narcotic book indicated a staff member removed two oxycodone tablets approximately two hours after they gave the resident two tablets. This would indicate the staff member inaccurately gave the resident two tablets of oxycodone approximately two hours before she was supposed to receive it.

The facilities medication administration record (MAR) is an electronic recordkeeping system which electronically records when staff document medication administration. The MAR indicated staff members accurately administered the medication, within appropriate time intervals according to the physician's order for administration.

During an interview, a nurse said he was not aware of the concern the resident had a possible narcotic medication overdose until a law enforcement officer arrived at the facility. The nurse said the law enforcement officer arrived at the facility and together they reviewed the MAR and narcotic book. The nurse said there was a time discrepancy one day in the narcotic book, so he spoke to the staff involved. The nurse said the staff member inadvertently wrote the date into the narcotic book instead of the time. The nurse said the staff member gave the oxycodone tablets appropriately as electronically documented in the MAR. The nurse said at the time the resident fell; he was on the phone talking with the staff member who was in the room with the resident. The nurse said he heard the resident talking and answering his questions appropriately. The nurse said he told the staff member to send the resident into the hospital because she had recent knee surgery, and they were concerned the resident injured her knee.

Law enforcement records indicated an officer spoke to the staff member who wrote in the narcotic book. Law enforcement records indicated the staff member said they made a documentation error in the narcotic book but gave the medication accurately.

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 appropriately coordinated medical care for the resident.

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
	32938	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JANESVILLE SENIOR LIVING LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL329385408C/HL329383002M HL329384207C/HL329382362M On August 7, 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 thirty-three residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL329385408C/HL329383002M, tag identification 630. No correction order is issued for HL329384207C/HL329382362M.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) and failed to implement person centered individual interventions after sexual assault allegations, delusional behavior (psychosis), and street drug use for one of two residents (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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). The findings include: R1 admitted to the licensee on for diagnoses including bipolar two disorder and anxiety. R1's service plan dated August 7, 2025, (effective date) indicated she required assistance with bed	0 630		

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0 630	Continued From page 2 making, transportation, bathing, meals, housekeeping, laundry, medication administration, safety checks, and behavior management. The service plan indicated interventions for behavior management indicated R1 was verbally aggressive towards others, and demanding to staff regarding food items. The service plan indicated staff should assist her to relax with music or television, take her dog outside, and re-approach. The service plan indicated, the licensee added a behavior management service on March 3, 2025, to include two staff members for all cares and medication administration. Law enforcement records dated February 19, 2025, indicated they went to the licensee because R1 alleged unlicensed personnel (ULP)-H sexually assaulted her. The records indicated R1 told the law enforcement officer ULP-H put her fingers and balls attached to a string in her vagina and forced R1 and another resident to drink urine. R1 told the law enforcement officer ULP-H licked her vagina, and the other resident's stomach. The records indicated both residents went to the hospital for a sexual assault examination. Law enforcement records indicated there was no evidence a sexual assault occurred. R1's IAPP dated February 19, 2025, indicated R1 had poor memory, and required re-direction. The IAPP indicated she had impulse control issues. The IAPP indicated R1 had no chemical and/or other medication abuse. The IAPP failed to indicated R1 had an allegation of sexual abuse and individualized interventions to protect R1 from abuse and address any behaviors of accusations. Progress notes dated February 20, 2025, at 4:37	0 630		

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0 630	Continued From page 3 p.m., read, "drug seeking noted." No further documentation or information regarding the notation. R1's nursing assessment dated March 3, 2025, indicated R1 had cognitive decline, bipolar two disorder, and anxiety issues. The assessment indicated R1 scored 18/30 on MOCHA test (memory test indicting mild memory impairment). The assessment indicated R1 had verbal outbursts, repetitive thoughts/statements, and socially inappropriate behaviors. R1 required occasional redirection due to "vaping" in the hallways, and her demanding behavior. The nursing assessment indicated R1 had no history of miss use or drug diversion. The assessment failed to identify R1 used street drugs including methamphetamine. The assessment failed to identify R1 had a pain contract with a physician at a pain clinic. The assessment failed to identify R1 had a history of unfounded allegations of sexual assault. The nursing assessment failed to identify how R1's delusional behavior impacted other resident's and failed to identify person centered individualized interventions to mitigate the risk of harm to others. R1's physician visit record dated April 3, 2025, at 10:00 a.m., indicated R1 tested positive for benzodiazapines, amphetamines, opiates, and methamphetamines on February 9, 2025. The record indicated R1 had a pain contract, which R1 avoided due to the positive lab results. The record indicated R1 had dementia, paranoia due to bipolar disorder and required psychotropic medication to manage this. R1's IAPP failed to be updated with to accurately reflect R1's self abuse related to drug use when R1 tested positive for methamphetamines on	0 630		

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0 630	Continued From page 4 February 9, 2025. The IAPP failed to identify R1 had a pain contract with a physician at a pain clinic. The IAPP lacked person centered individualized interventions to minimize R1's risk of harm due to use of methamphetamines. The IAPP failed to identify measures to monitor, manage, or coordinate care according to R1's pain contract. On August 7, 2025, at 2:01 p.m., director of nursing (DON)-A said he started working at the licensee after these instances occurred. DON-A said he heard from other staff members R1 had an extensive history of drug abuse and left the licensee's building with other people and returned appearing "sedated," so staff suspected drug use. DON-A said this was just "hearsay," however this led him to investigate her medical records, and he found the pain management clinic discontinued R1's pain contract because of her continued opioid drug use. DON-A said the pain contract violation occurred prior to his employment. On August 18, 2025, at 3:25 p.m., the surveyor asked DON-A to confirm if the IAPP dated February 19, 2025, was the only IAPP completed by the licensee. DON-A said he would double check to confirm, however he said he believed it was. DON-A said this was due to a lot of circumstances. DON-A said he did not complete an IAPP for the resident since he started working mid-April 2025. On August 19, 2025, at 8:48 a.m. DON-A confirmed R1 had no further IAPP assessments. The licensee's policy titled, Individual Abuse Prevention Plans, dated November 7, 2024, indicated the IAPP would include specific measures to minimize the resident's risk of	0 630		

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0 630	Continued From page 5 abuse. TIME PERIOD OF CORRECTION: Seven (7) Days	0 630		