Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333101740M
Compliance #: HL333106762C

Date Concluded: April 3, 2026

Name, Address, and County of Licensee Investigated:
The Meadows of Wadena
110 Hemlock Avenue NW
Wadena, MN 56482
Wadena 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 alleged perpetrator (AP) neglected the resident when she failed to provide services as directed by the service plan. The AP only checked on the resident once during her shift instead of every two hours and the resident did not receive prescribed pain medication. The resident experienced excruciating pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident had scheduled services including turning and repositioning, toileting, and oral cares, that the AP did not perform. The AP documented they had been completed but camera footage did not show the AP performing the scheduled services. There was not a preponderance of evidence neglect occurred as it was unable to be determined when the resident's pain started. The prescribed medication was not scheduled, only to be given PRN and it was unable to be determined if the AP would have administered a PRN medication during her shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included hypertension (high blood pressure) and heart failure. The resident's service plan included assistance with activities of daily living and medication administration. The resident's assessment completed a few hours before the AP's shift started, indicated the resident had a change in condition and was now bed bound due to his decline. The resident depended on staff to perform all cares and had cognitive impairment. The resident was also receiving hospice services.

The resident's record indicated he was receiving end of life care and a few hours before the AP's shift started, it was noted the resident had a change in condition. The registered nurse (RN) noted he had increased knee pain, difficulty transferring, and was expected to remain bed bound due to his decline. The RN updated the hospice nurse about his change in condition and increased pain. The resident's PRN oxycodone pain medication was changed by the hospice nurse to be given every two hours instead of every four hours.

The resident had several scheduled services overnight. Staff were to check and change his incontinence product every two hours, perform oral care every two hours, position and reposition every two hours, and complete a safety check every two hours. Instructions for the safety check included to check on the resident to make sure they were safe and their needs were met and to provide assistance if needed. The AP documented that services had been completed at 11:00 p.m., midnight, 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., and 5:00 a.m.

Progress notes indicated the RN was notified at 6:50 a.m. by day shift staff who reported the resident had ten out of ten pain. The RN looked at the resident's medication administration record (MAR) and noted he had not received PRN pain medication for ten hours. Hospice was notified after two PRN medications were not effective and new orders for increased pain medications were given. By 1:00 p.m., the resident's pain decreased to a five out of ten. Facility staff continued updating hospice and administering additional PRN pain medications. The resident passed away the next day.

During an interview, the AP stated when she came onto the overnight shift, the evening shift did not communicate anything related to changes with the resident or anything about giving additional PRN medications. The AP stated she had worked several days in a row and had not been feeling well that night. The AP stated she and a ULP from the assisted living side changed the resident and offered him morphine at that time but the resident declined. The AP stated the other ULP checked on the resident for her when she was on a break.

During an interview, the ULP who worked the overnight shift on the assisted living side that night stated she came over to memory care to help the AP provide cares if a resident needed an assist of two staff. The ULP stated she came over to memory care twice that shift, and they changed the resident's brief once around the middle part of their shift and checked his brief and it was dry towards the end of the shift. The ULP stated she knew the resident was on end-of-life care but wasn't sure how often he had services scheduled as she was not assigned to work on that side. The ULP did not indicate the resident was in pain during their interactions with the resident that evening.

During an interview, the RN stated the resident began to decline and have a change in condition a few hours before the AP's shift started. The RN stated she requested for hospice to schedule the PRN medications so they could ensure his pain was managed, but it was not hospice's policy to have the medication scheduled as it had to be given PRN first. The RN stated she sent a communication out to staff, including the AP, that informed them of the change in his condition and with his PRN medications and that staff should anticipate pain and administer the PRN medications when they checked on the resident. The RN stated the AP should have followed that guidance and if there were questions, she was trained to contact the RN. The RN stated after reviewing camera footage, it was confirmed the AP only entered the resident's room once on her shift and spent seven minutes in his room, despite documenting she performed all scheduled services.

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: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

When the resident had uncontrolled pain, management investigated what medications he had been given. Upon discovering he hadn't been given PRN medications for several hours, they reviewed security camera footage and only observed the AP entering the room once. The AP was terminated and a MAARC report was filed. Facility staff were retrained.

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
	33310	A. BUILDING: _____ B. WING _____	C 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF WADENA	110 HEMLOCK AVENUE NW WADENA, MN 56482

(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 March 20, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL333101740M/ #HL333106762C No correction orders are issued.	0 000		