Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL301089862M
Compliance #: HL301089761C

Date Concluded: April 29, 2025

Name, Address, and County of Licensee Investigated:
Water's Edge
800 Agency Trail
Mankato, MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 did not administer her insulin. As a result, her blood glucose level rose above 500, and she was subsequently sent to the emergency room (ER).

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not have insulin available to administer and the unlicensed caregivers did not notify the nurse. Additionally, the resident had multiple high blood sugars, but the unlicensed caregivers did not notify the nurse until days later, when one of the caregivers finally notified the manager about the resident's abnormal result.

The investigator conducted interviews with administrative staff. The investigation included review of the resident's records, incident reports, policies, and procedures.

The resident lived in a secured memory care unit within an assisted living facility. The resident's diagnoses included Alzheimer's disease and diabetes mellitus. The resident's service plan included medication administration and assistance, as well as blood sugar monitoring as ordered by the physician.

The facility incident report dated the 6th of the month indicated a manager received a phone call from the lead unlicensed caregiver, informing her that the resident's insulin had been out since the 2nd of the month. The manager contacted the pharmacy, but the insulin could not be filled until a prior authorization was received. The primary physician was contacted for an updated insulin prescription.

The resident's blood sugar record showed a level of 513 on the 3rd, no blood sugar recorded on the 4th, and a level of 567 on the 5th of the month.

The resident's progress notes indicated she was sent to the emergency room (ER) for evaluation on the 6th. The resident showed no adverse effects from not receiving insulin, aside from elevated blood sugar levels.

The progress notes also indicated that the resident returned to the facility from the ER in the evening. She showed no signs of diabetic ketoacidosis, received IV fluids, and insulin in the ER. There were no changes to her medication.

During an interview, the manager stated that one of the medication technicians had removed the resident's insulin from the medication cart and failed to reorder it or check the refrigerator for any available supply. As soon as the manager was notified, she sent the resident to the ER for evaluation. The manager stated the resident's blood glucose was checked daily, and unlicensed caregivers were to notify the nurse of any abnormal results above 400 or below 100. Following the incident, all unlicensed caregivers whose duties include medication pass including insulin administration along with the nurse were re-educated. The manager acknowledged that both the nurse and unlicensed caregivers had overlooked the blood sugar results.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: No, attempts unsuccessful
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility sent the resident to the ER, contacted the pharmacy, and obtained an updated prescription for insulin. All staff members were re-educated.

Action taken by the Minnesota Department of Health: The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	30108	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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 In accordance with Minnesota Statutes, sectio 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. On April 1st, 2025, the Minnesota Department of Health initiated an investigation of complaint HL301089862M/HL301089761C. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	