*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306174967M
**Compliance #:** HL306171214C

**Date Concluded:** November 12, 2025

**Name, Address, and County of Licensee Investigated:**
Vitacare Living
23 Waterview Drive
Proctor, MN 55810
St. Louis County

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

**Evaluator's Name:** Deb Schillinger RN BSN
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 she was admitted to the facility without oxygen or medications. The resident did not receive scheduled inhalers and medications for 2 days, then was readmitted to the hospital where she later died.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected the resident when it did not assure all prescribed medications, including Valium (a benzodiazepine medication) and medical equipment, including a nebulizer and oxygen concentrator were available on admission. Neither the resident's orders nor the facility policies and procedures were followed by facility staff, therefore the resident failed to receive all prescribed medications. The resident was re-hospitalized on the third day after admission and died in the hospital 10 days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted pharmacy, hospital staff and providers. The investigation included review of the resident record, death record, hospital records, pharmacy records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and facility staff interactions during an onsite visit.

The resident resided in an assisted living secured memory care unit. The resident's diagnoses included end stage COPD (a progressive lung disease that makes breathing difficult), chronic benzodiazepine (Valium) use, a seizure disorder, chronic pain and recent stroke. The resident's temporary service plan included assistance with medication and oxygen management, toileting, bathing, and dressing. The resident did not have a comprehensive assessment completed, but previous assessments from hospital records and family members indicated the resident was able to make her own decisions and needed assistance with mobility.

A concern arose the resident was admitted to the facility without the necessary medications and equipment needed to provide her baseline needs.

The resident admitted to the facility on Day 1 and resided at the facility until Day 3 when transferred to the hospital by emergency medical services (EMS).

**Day 1**

- At 2:37 p.m. the resident arrived at the facility, the resident did not have or have orders for an oxygen concentrator, nebulizer machine or a bed. The facility staff found an extra oxygen concentrator and bed within the facility for the resident to use.
- Valium
    - The hospital discharge summary indicated the residents long standing Valium prescription (a benzodiazepine medication used to treat seizures and anxiety) had been discontinued.
    - The resident's progress notes indicated an appointment was arranged for the resident to be seen the next day by the in-house provider to reestablish chronic Valium orders. The progress notes indicated the date for the note was on the day of admission, however the progress notes were not signed by the nurse until the following month.
- End-Stage COPD medications
    - The resident's admission orders included the following medication orders for end stage COPD:
    - DuoNeb (Ipratropium-Albuterol), 3mg/3ml (milligrams/milliliter), inhale 3 ml using a nebulizer four times daily.
    - Stiolto (Tiotropium Bromide-olodaterol) inhaler, one puff every twelve hours.
    - The EMAR at 8:00 p.m. indicated the DuoNeb ordered was not administered because the medication was not available.

- The EMAR 8:00 p.m. indicated the Stiolto inhaler was not administered because the medication was not available.

**Day 2**

- The medical provider visited the resident at the facility and medication orders were given.
- Valium
  - At 1:00 p.m. pharmacy records indicated an order for Valium was received from the medical provider.
  - At 1:24 p.m. the resident's medication administration record (EMAR) reflected the Valium order was added for unlicensed caregivers to administer four times daily.
  - At 2 p.m. the EMAR indicated the Valium was not given as the medication was out of stock and the nurse was notified.
  - At 2:42 p.m. a timestamped pharmacy record indicated the delivery of 112 tabs of Valium 5 mg to the facility.
  - A transfer form signed by nurse #1 indicated all previous scheduled medications were received from the previous assisted living facility.
  - At 8 p.m. the EMAR indicated Valium was not given as no medication was available.
  - While the facility unlicensed caregivers documented the Valium as not available to administer to the resident, pharmacy delivery forms and transfer forms indicate the medication had been delivered and was available to be administered to the resident.
- End-Stage COPD medications
  - The EMAR at 8:00 a.m. indicated all medications ordered had no documentation indicating why the medications were not administered.
  - A transfer document from the facility the resident had previously lived [facility #2] at indicated 3 Stiolto inhalers and 510 DuoNeb doses were received. The same form was signed by one nurse from each facility.
  - A progress note at 10:42 a.m. from facility #2 indicated all the resident's belongings had been delivered to the facility.
  - During an interview, the nurse from facility #2 stated the resident's medications were delivered to the facility prior to 12:00 p.m. on June 20, 2025, along the resident's personal belongings.
  - The EMAR at 12:00 p.m. indicated the ordered DuoNeb medication was available, but a nebulizer (machine that turns liquid medication into a fine mist to inhale into lungs) was not.

- The EMAR at 4:00 p.m. indicated the ordered DuoNeb medication was available, but a nebulizer was not.
- The EMAR at 8:00 p.m. indicated the ordered Stiolto inhaler was not available to be administered.
- The EMAR at 8:00 p.m. indicated the ordered DuoNeb medication was available, but a nebulizer was not.

**Day 3**

- At 2 a.m. the EMAR indicated scheduled Valium was not given because no medication was available.
- At 6 a.m. an unlicensed caregiver assisted the resident to the bathroom, where she noticed the resident had increased dyspnea, was diaphoretic and pale. The unlicensed caregiver notified the on call nurse and emergency medical services (EMS) was called. Nurse #1 came to building to print paperwork for EMS.
- At 8:50 a.m. The emergency department (ED) provider notes indicated the resident arrived in the hospital ED in acute distress. The report indicated she was ill appearing, lethargic, diaphoretic, with pupils dilated and in respiratory distress. The resident's vital signs indicated her blood pressure was very low (76/52), her respiratory rate was high (32), her heart rate was high (144). The ED report indicated the resident required intubation shortly after arriving in the ED and was then transferred to the intensive care unit with a diagnosis of cardiogenic shock. The resident died ten days later.

During an interview, a nurse manager stated she screened the resident's medical records and completed a paper pre-assessment form dated the day of admission, however she did not see the resident nor was she in the building on the day of admission or the following two days the resident was in the facility. The nurse manager stated there was not a comprehensive assessment documented by nurse #1, this is normally done by facility nurse supervisor, who was nurse #1 at the time of the admission.

During an interview, nurse #1 stated she was not involved with the admission process for this resident. She stated she would normally complete a preadmission screen for new residents, but she was not aware of this admission until the day the resident was to be admitted to the facility. Nurse #1 stated there was no comprehensive assessment completed on admission because the nurse manager stated she would complete the comprehensive assessment. Nurse #1 went on to state that on the morning the unlicensed caregiver called to report the resident wanted to go to the hospital, she later called nurse #1 back stating the resident did not want to go to the hospital, that she just wanted her anxiety medication.

During an interview, the regional manager stated the referral process begins when she receives a request for admission and, after review, she will send on to the nurse manager to review. If appropriate for possible admission, the nurse manager then sends the facility nurse to visit with the potential new resident and to complete an in-person preadmission assessment. The regional director stated she was not sure if an in person preassessment visit was completed for the resident. The manager stated she only saw the resident briefly on the day of admission when she stated she found an oxygen concentrator for the resident to use, then the resident wanted to rest. The regional manager stated she is not a nurse but handles the financial part of the admission. She stated the hospital social worker was coordinating and managing the delivery of the resident's personal belongings that were scheduled to be delivered on the day of admission, but the delivery was postponed by the previous facility prior to the resident's arrival. The regional manager stated the facility did not call the previous facility nor did she arrange for pickup of the resident's medications, oxygen concentrator or nebulizer machine from the previous facility prior to the resident's admission to the facility.

During an interview, the hospital social worker stated he had worked with the regional manager to arrange the admission to the facility. He stated the regional manager approved the admission and was aware the resident's belongings would not arrive until a later time. The hospital SW stated the regional manager said the facility had the ability to take care of the resident until her belongings were delivered to the facility.

During an interview, family member #1 stated the resident called after admitted to the facility and was very worried as she did not have anxiety medication available. The resident had taken anxiety medication for at least 20 years and had been taking the medication at least four times per day. In addition to the Valium not being given, the resident was not receiving her inhalers or nebulized medications for her breathing. Family member #1 stated a nebulizer machine was found in a box when the resident's personal belongings were picked up from the facility after her death.

During an interview, family member #2 stated the resident was in the hospital for eleven days prior to the facility admission. She stated she had worked with the hospital social worker, who was finding the resident a new facility placement. She stated she had an understanding the resident would discharge to the new facility on Monday and spoke to the facility regional manager before the admission to assure all medications, equipment and belongings would be available. Family member #2 was assured by the facility regional manager all would be available. Family member #2 received a voicemail the next day, on Thursday, from the hospital SW, the resident was discharged to the new facility. The resident remained at the facility for two days without necessary medications and equipment before being transferred by EMS back to the hospital in distress on the third day.

Additionally, family member #2 reported she called the facility several times but was unable to reach facility staff. She stated she left messages expressing concern the resident was not

receiving medication and should be sent back to the hospital. Family member #2 stated no one returned her calls.  Family member #2 continued to call the facility and did reach a facility staff member on Day 3, after the resident had been transferred to the hospital and was informed the resident was sent to the hospital, but was not informed the resident was having difficulty breathing.  Family member #2 thought her phone messages were received, and the resident had been sent to the hospital as she requested.

During an interview, the medical provider stated the effect of the resident not receiving the ordered Valium and other medications could be increased shortness of breath and increased anxiety.

The product monograph for Valium (diazepam), from AA Pharma indicated an abrupt withdrawal of Valium can produce severe or life-threatening symptoms and discontinuation of Valium should be gradually tapered.  Some symptoms of abruptly withdrawing Valium can include the following:

- Severe confusion
- Irregular heartbeat
- Excessive sweating
- Severe anxiety
- Panic attack

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**: No, VA is deceased
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:** the facility transferred the resident when a change of condition was reported.

**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
St. Louis County Attorney
Proctor City Attorney
Proctor Police Department
Minnesota Board of Nursing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30617 | A. BUILDING: _____ B. WING _____ | C 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VITACARE LIVING | 23 WATERVIEW DRIVE PROCTOR, MN 55810 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL306171214C /#HL306174967M<br><br>On August 27, 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 28 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued that were not issued at the time of immediate correction orders.<br><br>The following correction order is issued/orders are issued for #HL306171214C /#HL306174967M, tag identification 0900, 1610,1760 and 2360. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 900 SS=D | 144G.50 Subdivision 1 Contract required | 0 900 | | |

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| 0 900 | Continued From page 1<br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.<br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.<br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.<br>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content on, or before, the date of admission for one of one resident (R1). | 0 900 | | |

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| 0 900 | Continued From page 2<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident'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).<br><br>The findings include:<br><br>R1 was admitted and began to receive assisted living services on the afternoon of June 19, 2025.<br><br>R1's diagnoses included end stage COPD (a progressive lung disease that makes breathing difficult), chronic benzodiazepine (Valium) use, a seizure disorder, chronic pain and recent stroke. Medical records indicated R1 was able and made own decisions regarding care.<br><br>R1's Assisted Living Contract dated June 19, 2025, lacked a signature or other authentication by the resident. A handwritten note on the admission paperwork by nurse-D indicated "family declined to complete and return via email" dated July 29, 2025.<br><br>A progress note dated June 19, 2025, [electronically signed on July 1, 2025, at 1:33 p.m.] included a statement that R1's admission paperwork would be completed at a later time with R1's daughter and power of attorney.<br><br>During an interview on August 27, 2025, at 1:25 p.m. manager-A, who was also nurse, stated she oversees several facilities in the area. | 0 900 | | |

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| 0 900 | Continued From page 3<br><br>Manager-A stated she regularly completes a handwritten RN comprehensive assessment form when she completes a medical record review for potential new resident referrals. Manager-A stated these paper forms were used for all documentation prior to the adaptation of the electronic medical record (EMR) that is now used for all resident documentation currently in the facility. Manager-A stated she handed off the preadmission medical record review and care plan to the facility nurses for reference, then the comprehensive assessment would be done by the facility nurse, the manager reiterated the handwritten form titled "RN COMPREHENSIVE ASSESSMENT" was only a review of the resident's medical record. Manager-A stated no comprehensive assessment was documented and was unaware of why the assessment was not completed. During the same interview, Manager-A stated documentation indicated the resident declined to sign the admission contract, however she would have had the resident signed a form or a note that acknowledged her wishes for compliance reasons.<br><br>During an interview on September 9, 2025, at 11:02 a.m., a family member, FM-G stated she was asked to signed admission papers when picking up resident belongings on July 15, 2025. FM-G stated she was not notified before that date she needed to sign admission documents for R1. FM-G later stated that R1 was able to make her own decisions, and it would have been out of character for R1 to request FM-G to sign documents.<br><br>A licensee policy regarding Admissions was requested but not provided. | 0 900 | | |

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| 0 900 | Continued From page 4<br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 900 | | |
| 01610 SS=D | 144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br><br>This MN Requirement is not met as evidenced by:<br>Based on document review and interview, the licensee failed to ensure a registered nurse (RN) conducted an assessment of the physical and cognitive needs prior to signing a contract or move in date for one of one resident (R1) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and | 01610 | | |

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| 01610 | Continued From page 5<br>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).<br><br>The findings include:<br><br>R1 was admitted and began to receive assisted living services on the afternoon of June 19, 2025.<br><br>R1's diagnoses included end stage COPD (a progressive lung disease that makes breathing difficult), chronic benzodiazepine (Diazepam) use, a seizure disorder, chronic pain and recent stroke.<br><br>A review R1's medical record did not identify a completed comprehensive assessment on or before the initiation of services by a registered nurse (RN) and failed to include the required content of a comprehensive RN assessment.<br><br>During an interview on August 27, 2025, at 1:25 p.m. manager-A, who was also nurse, stated she oversees several facilities in the area. Manager-A stated she regularly completes a handwritten RN comprehensive assessment form when she completes a medical record review for potential new resident referrals. The manager reported these paper forms were used for all documentation prior to the adaptation of the electronic medical record (EMR) that is now used for all resident documentation currently in the facility. Manager-A states she handed off the preadmission medical record review and care plan to the facility nurses for reference, then the comprehensive assessment would be done by the facility nurse, the manager reiterated the handwritten form titled "RN COMPREHENSIVE | 01610 | | |

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| 01610 | Continued From page 6<br><br>ASSESSMENT" was only a review of the resident's medical record. Manager-A stated no comprehensive assessment was documented and is unaware of why the assessment was not completed.<br><br>A review of R1's unsigned assisted living contract agreement under Assessment and Monitoring, page 12, indicated: "an individualized initial assessment will be conducted in person by a Registered Nurse prior to the date on which the Resident executes a contract with the provider or on the date the Resident moves in, whichever is earlier."<br><br>A licensee policy regarding Admissions was requested but not provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01610 | | |
| 01760 | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. | 01760 | | |

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| 01760 | Continued From page 7<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to ensure medications were readily available to administer as ordered for one of one resident (R1). R1 was admitted to the facility without necessary medications available, then when those same medications were available on June 20, 2025, the medications were not administered. R1 was transferred back to the hospital on June 21, 2025, and died ten days later.<br><br>This practice resulted in a level five violation (a violation that results in serious injury 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).<br><br>The findings include:<br><br>R1 was admitted from the hospital and began to receive assisted living services on June 19, 2025 at 2:37 p.m. R1 had previously lived at a different facility (facility #2) and the facility was making arrangements to have equipment and medications from facility #2.<br><br>R1's diagnoses included end stage COPD (a progressive lung disease that makes breathing difficult), chronic benzodiazepine (Diazepam) use, a seizure disorder, chronic pain and recent stroke.<br><br>A review of R1's medical record lacked a comprehensive and medication assessment completed by a registered nurse prior to or upon admission to the facility. | 01760 | | |

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| 01760 | Continued From page 8<br><br>End Stage COPD Medications<br>R1's admission orders dated June 19, 2025, included the following medication orders for end stage COPD:<br>*DuoNeb (Ipratropium-Albuterol), 3mg/3ml (milligrams/milliliter), inhale 3 ml four times daily<br>*Stiolto (Tiotropium Bromide-olodaterol) inhaler, one puff every twelve hours<br><br>A pharmacy delivery record on June 19, 2025, at 6:34 p.m. indicated several medications, including 360 DuoNeb doses, were delivered to the facility.<br><br>The EMAR dated June 19, 2025, at 8:00 p.m. indicated the DuoNeb ordered was not administered because the medication was not available.<br><br>The EMAR dated June 19, 2025, at 8:00 p.m. indicated the Stiolto inhaler was not administered because the medication was not available.<br><br>The EMAR dated June 20, 2025 at 8:00 a.m. for all medications ordered was blank, no documentation was available indicating why the medication was not administered.<br><br>A transfer document from facility #2 dated June 20, 2025 which indicated 3 Stiolto inhalers and 510 DuoNeb doses were received which was signed by one nurse from each facility.<br><br>A progress note dated June 20, 2025, at 10:42 a.m. from facility #2 indicated all of R1's belongings had been delivered to the facility.<br><br>During an interview on October 21, 2025, the | 01760 | | |

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| 01760 | Continued From page 9<br><br>facility #2 nurse stated R1's medications were delivered to the facility prior to 12:00 p.m. on June 20, 2025, along R1's personal belongings.<br><br>The EMAR dated June 20, 2021 at 12:00 p.m. indicated the ordered DuoNeb medication was available, but a nebulizer (machine that turns liquid medication into a fine mist to inhale into lungs) was not.<br><br>The EMAR dated June 20, 2021 at 4:00 p.m. indicated the ordered DuoNeb medication was available, but a nebulizer was not.<br><br>The EMAR dated June 20, 2021 at 8:00 p.m. indicated the ordered Stiolto inhaler was not available to be administered.<br><br>The EMAR dated June 20, 2021 at 8:00 p.m. indicated the ordered DuoNeb medication was available, but a nebulizer was not.<br><br>An incident report on June 21, 2025, at 7:32 a.m. indicated emergency medical services (EMS) were called after R1 requested to go to hospital when unable to catch her breath. The same document indicated medical provider was not notified until June 26, 2025. The document was electronically signed on July 8, 2025, at 8:51 p.m.<br><br>A review of R1's medical record found it lacked documentation R1's medical provider was notified R1's end-stage COPD-related medications were not given as ordered. The review did not identify documentation follow-up procedures to meet the resident's needs.<br><br>Diazepam | 01760 | | |

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| 01760 | Continued From page 10<br><br>R1's discharge instructions on June 19, 2025, from the hospital indicated her long-term order for Diazepam was discontinued.<br><br>A progress note on June 19,2025 at 2:37 p.m. but. indicated the facility nurse questioned the hospital SW regarding medication clarification regarding Diazepam discontinuation. The document was electronically signed on July 1, 2025, at 1:33 p.m.<br><br>A progress note on June 19,2025 at 3:02 p.m. indicated arrangements were made for R1 to be seen by the rounding medical provider on June 20, 2025, to reinstate the long-standing Diazepam orders. The document was electronically signed on July 9, 2025, at 8:38 p.m.<br><br>A transfer document from facility #2 dated June 20, 2025 indicated 158 Diazepam doses were delivered to the facility.<br><br>A progress note dated June 20, 2025, at 10:42 a.m. from facility #2 indicated all of R1's belongings had been delivered to the facility.<br><br>During an interview on October 21, 2025, the facility #2 nurse stated R1's medications were delivered to the facility prior to 12:00 p.m. on June 20, 2025, along R1's personal belongings.<br><br>A pharmacy form dated June 20, 2025 at 1:00 p.m. indicated an order was received from R1's medical provider to reinstate the Diazepam 5 mg order to be administered four times daily.<br><br>The EMAR for June 20, 2025 at 1:24 p.m. indicated the diazepam was added for unlicensed | 01760 | | |

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| 01760 | Continued From page 11<br><br>caregivers to administer four times daily, at 2pm, 8 p.m. 2 am and 8 am.<br><br>The EMAR on June 20, 2025 at 2 p.m. indicated the Diazepam 5 mg order was skipped as medication was not available for administration and the nurse was notified.<br><br>A pharmacy delivery record dated June 20, 2025, at 2:42 p.m. indicated 112 Diazepam 5 mg tabs were delivered to the facility.<br><br>The EMAR for June 20, 2025 at 8 p.m. indicate the Diazepam 5mg ordered was not available for administration.<br><br>The EMAR for June 21, 2025 at 2 a.m. indicate the Diazepam 5mg ordered was not available for administration.<br><br>A review of R1's medical record lacked documentation the medical provider was notified or planning put in place to meet R1's needs.<br><br>The product monograph for Diazepam, from AA Pharma dated January 21, 2022, indicated an abrupt withdrawal of Diazepam can produce severe or life-threatening symptoms and discontinuation of Diazepam should be gradually tapered. Some symptoms of abruptly withdrawing Diazepam can include the following:<br>*Severe confusion<br>*Irregular heartbeat<br>*Excessive sweating<br>*Severe anxiety<br>*Panic attack<br><br>During an interview on August 27, 2025, at 1:25 p.m. manager-A, who was also nurse, stated she | 01760 | | |

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| 01760 | Continued From page 12<br><br>oversees several facilities in the area. Manager-A stated she regularly completes a handwritten RN comprehensive assessment form when she completes a medical record review for potential new resident referrals.<br><br>The manager reported these paper forms were used for all documentation prior to the adaptation of the electronic medical record (EMR) that is now used for all resident documentation currently in the facility. Manager-A states she handed off the preadmission medical record review and care plan to the facility nurses for reference, then the comprehensive assessment would be done by the facility nurse, the manager reiterated the handwritten form titled "RN COMPREHENSIVE ASSESSMENT" was only a review of the resident's medical record. Manager-A stated no comprehensive assessment was documented and is unaware of why the assessment was not completed. During the same interview, Manager-A stated documentation indicated the resident declined to sign the admission contract, however she would have had the resident signed a form or a note that acknowledged her wishes for compliance reasons. During the same interview, Manager-A stated the nurse should have questioned why the long-standing Diazepam order was discontinued. However, was unsure why the Diazepam was not administered after an order was received to reinstate from the rounding provider on June 20, 2025. Manager-A stated medications received from another facility could be used if the dosages matched the orders.<br><br>During an interview on August 27, 2025, at 2:30 p.m., manager-C stated she worked with the hospital discharge planner on R1's admission for | 01760 | | |

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| 01760 | Continued From page 13<br><br>Thursday, June 19, 2025. Manager-C stated it is facility policy not to admit residents on Fridays. She later stated she handles the financial portion of facility admissions as she is not a nurse. She stated she was unsure if a preadmission assessment was completed by a nurse before R1's admission. Manager-C stated resident belongings scheduled to be delivered on Thursday were cancelled and the facility had to find an oxygen concentrator, bed and wheelchair for the resident to use.<br><br>During an interview on August 27, 2025, at 3 p.m., nurse-D stated during the admission process a preadmission assessment would be completed by the facility nurses. Nurse-D stated neither she nor nurse-H completed a preadmission assessment for R1, and as a result R1 arrived at the facility without all necessary medication orders and equipment. Nurse-D stated for new resident admissions, the hospital sends medication orders for all medications and necessary equipment. She then stated the hospital did not send orders for all medications and equipment, as needed. She stated facility staff members were able to find an extra wheelchair and oxygen concentrator for the resident to use but could not locate a nebulizer machine to administer end stage COPD medications.<br><br>During an interview on September 11, 2025, at 11:00 a.m., nurse-H, stated the normal process for new admission is for the facility nurse to complete a preadmission assessment to assure a resident would be appropriate for admission and make sure all needs could be in place prior to admission. R1's admission did not follow the same process as the Manager-C arranged for the | 01760 | | |

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| 01760 | Continued From page 14<br><br>admission without a preadmission assessment. Nurse-H discovered on R1's arrival to the facility that R1's long-standing Diazepam order had been discontinued. She stated no report was received prior to R1's admission and R1 also arrived without necessary equipment including an oxygen concentrator and nebulizer machine.<br><br>An incident report dated on June 21, 2025, at 7:32 a.m. [electronically signed July 8, 2025, at 8:51 p.m.] indicated emergency medical services (EMS) were called after R1 requested to go to hospital when unable to catch her breath. The same document indicated medical provider was not notified until June 26, 2025.<br><br>R1's hospital records indicated she arrived at the hospital in acute respiratory distress, diaphoretic and with a rapid heart rate. R1 required intubation shortly after her arrival. R1 was admitted to critical care for cardiogenic shock, where she was unable to be weaned from the ventilator. R1 was extubated and died on July 1, 2025.<br><br>A licensee policy regarding medication orders, medications not given and receiving ordered medications from pharmacy. A policy was not provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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. | 02360 | | |

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| 02360 | Continued From page 15<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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 | | |