Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL355191641M
Compliance #: HL355192622C

Date Concluded: June 10, 2025

Name, Address, and County of Licensee Investigated:
Twin Valley Assisted Living
208 Oppegard Avenue NW
Twin Valley, MN 56584
Norman County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP), a facility nurse, neglected the resident when she failed to provide medication management services as ordered and repeatedly failed to ensure medications were refilled after being notified by caregivers that prescribed medications were unavailable. The resident's medications were not refilled timely, resulting in the resident missing several weeks of medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator, a registered nurse at the facility, failed to notify the resident's primary care provider that several medications were not being given because they ran out. In total, the resident missed at least 139 doses of medications over two months.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted the primary care provider and the case manager.

The investigation included review of the resident record, the AP's employee record, and related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, hypertension (high blood pressure), history of stroke, and type two diabetes. The resident's service plan included assistance with medication administration. The resident's assessment indicated facility staff were responsible for managing the resident's medication refills and all aspects of medication management/administration. The assessment failed to identify the resident used an outside pharmacy that would mail out medications, which could result in a delay in obtaining prescriptions. The assessment failed to identify how the facility would handle reordering if there was a delay in obtaining the resident's medications.

Month One
The medication administration record (MAR) indicated the resident missed up to 22 consecutive days of medication. The resident did not receive ten different medications including apixaban, an anticoagulant, metoprolol, a medication to lower blood pressure, metformin, a medication for high blood sugar, and mirtazapine, an antidepressant.

In total, the resident missed 121 scheduled doses. The MAR included documentation that the nurse was notified each time the medications were not given due to being out of stock. The resident's record lacked evidence the RN/AP notified the primary care provider or the resident's power of attorney that the medications were out of stock.

Month Two
The MAR indicated the resident missed up to five consecutive days of four scheduled medications. The resident did not receive melatonin, a medication for sleep, metoprolol, a medication for high blood pressure, gabapentin, a pain medication, and metformin, a medication for high blood sugar. In total, the resident missed 18 scheduled doses. The MAR included documentation that the nurse was notified each time the medications were not given due to being out of stock.

The resident's record lacked evidence the RN/AP notified the primary care provider or the resident's power of attorney that the medications were out of stock.

During an interview, the AP stated she had reordered the medications, but the pharmacy would often send medications she hadn't ordered and not send the ones she did order. The AP stated she was not aware the resident was out of medications and that staff had not told her he was out of medication. The AP stated the primary care provider should have been updated that the resident was out of medications and that there should have been follow up with the provider and family to see if they wanted to get a temporary supply from another pharmacy.

During an interview, an unlicensed personnel (ULP) stated when a medication was out, staff would document the medication as declined and they would make a note the nurse was

notified and send the nurse a message in their electronic medical record so each time a note says nurse notified, it would mean a message was sent to the nurse. The ULP stated the nurse was aware medications were out and the AP was right there with her on a day a medication wasn't available, and the AP told her that it was on order. The ULP stated besides notifying the nurse, there wasn't much more she could do if a medication was out as the nurse would be the one contacting providers or the pharmacy to follow up on things.

During an interview, the resident's primary care provider (PCP) stated the AP never reached out to her to notify her the resident had missed several doses of medications or that there were issues with obtaining refills. The PCP stated she would have expected to be notified of any missed medications or issues with getting refills.

During an interview, the resident's power of attorney (POA) stated they were not aware the resident missed any doses of medications, and the facility had not reached out to say they were having trouble reordering medications.

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: Unable due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP was terminated. The facility reviewed its medication reordering procedures.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Norman County Attorney
Twin Valley City Attorney
Twin Valley 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
	35519	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY ASSISTED LIVING	208 OPPEGARD AVENUE NW TWIN VALLEY, MN 56584

(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: #HL355191641M/#HL355192622C On April 30, 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 15 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL355191641M/#HL355192622C, tag identification 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. 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person 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 required.	