Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307646582M
Compliance #: HL307649863C

Date Concluded: March 28, 2025

Name, Address, and County of Licensee Investigated:
The Lodges Company
27890 Natchez Avenue
Elko New Market, MN 55020
Scott County

Facility Type: Assisted Living Facility (ALF)

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 the resident's insulin was not refilled or administered per providers orders and the resident required hospitalization due to hyperglycemia.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While managing the resident's medications, the facility ran out of diabetic medications, including insulin. Additionally, the facility did not provide the necessary medications supplies, such as needles, so the resident's diabetic medication could be administered as ordered by his medical provider. The resident was hospitalized multiple times while the situation existed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the guardian and a pharmacy manager. The investigation included review of the resident record, hospital records, pharmacy records, facility incident reports, staff schedules, and related facility policy and procedures.

Also, the investigator observed the facility environment and interactions between resident and facility staff during an onsite visit.

The events in this investigation took place over several months; the names of the months have been replaced with numbers, but the day of the month was used as needed.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes. The resident's service plan included medication management and administration, including insulin and monitoring blood sugar four times per day. The resident's assessment indicated the resident was able to make decisions regarding his care and required assistance with insulin injections.

A concern arose the facility did not administer the resident's insulin as ordered by the medical provider.

A review of the resident's electronic medication administration record (EMAR) indicated the resident was prescribed:

- Humulin R (a short-acting insulin) to be injected three times daily with meals
- Basaglar (a long-acting insulin) to be injected twice daily
- Ozempic (a medication to lower blood sugar) to be injected weekly

Month #1

The EMAR for Month #1, day 14 indicated the resident was not administered the evening dose of Basaglar because there were no needles to inject the medication.

The EMAR for Month#1, day 15 indicated the resident's weekly Ozempic dose, Humulin R doses and Basaglar doses were not given because there were no needles to inject the medication.

The EMAR for Month #1, day 16 indicated the resident's Humulin R doses and Basaglar doses were not given because there were no needles to inject the medication.

The EMAR for Month #1, day 17 indicated the resident's Humulin R doses and Basaglar doses were not given because there were no needles to inject the medication.

The progress notes dated for Month #1, Day 17 indicated the resident was out of "non-wearable" diabetic supplies. The same document indicated the facility asked the medical provider to send a request for supplies to the local pharmacy. A review did not identify documentation specifically regarding insulin pen needles for administration.

The EMAR for Month #1, day 18 indicated the resident's Humulin R doses and Basaglar doses were not given because there were no needles to inject the medication.

The medical record for Month #1, day 18 indicated the resident was transferred to the hospital for high blood sugar, received treatment for high blood sugar levels and returned to the facility the same day.

The EMAR for Month #1, day 19 indicated the resident's Humulin R doses and Basaglar doses were not given because there were no needles to inject the medication.

The progress notes Month #1, day 19 indicated the local pharmacy could not fill order for test strips. A review did not identify documentation specifically regarding insulin pen needles for administration.

The EMAR for Month #1, day 20 indicated the resident's morning doses of Humulin R and Basaglar were not given because there were no needles to inject the medication.

The progress notes for Month #1, day 20 indicated the facility attempted to purchase pen needles on day 19 unsuccessfully. The same document indicated the facility contacted the pharmacy requesting pen needles for insulin administration be delivered ASAP.

The medical record for Month #1, day 20 indicated the resident was transferred to the hospital for high blood sugar, received treatment for high blood sugar levels and returned to the facility the same day. Hospital records indicated pen needles were provided to the resident upon discharge for insulin administration.

A review of the medical records for dates of Month #1, days 19-21, did not identify documentation indicating the facility contacted the medical provider requesting an order for the pen needles.

The progress notes for Month #1, day 22 indicated the resident was again transferred to the hospital, where the resident was admitted for high blood sugar and returned to the facility on day 24.

A review of the facility's medication error report log did not contain medication error reports for the resident during Month #1 containing corresponding dates for medications that were not administered.

M**onth #2**

The EMAR for Month #2, day 12 indicated the resident's weekly Ozempic dose was not administered because the medication was out of stock, and indicated the nurse was notified.

A review of the resident's medical record for Month #2 did not identify documentation indicating the medical provider was notified of missed medication doses nor further follow-up regarding the missed Ozempic dose.

A review of the resident's pharmacy documentation did not indicate Ozempic was ordered or delivered in Month #2.

A review of the facility's medication error report log did not contain a medication error report for the resident in Month #2 containing corresponding date for medications that were not administered.

Month #3
The EMAR for Month #3, day 3 indicated the resident's weekly Ozempic dose was not administered as the medication was out of stock.

The EMAR for Month #3, day 17 indicated the resident's weekly Ozempic dose and the Humulin R evening meal dose were not administered as the medications were out of stock.

The EMAR for Month #3, day 18 indicated the resident's Humulin R noon and evening meal dose were not administered as the medication was out of stock.

A pharmacy delivery record for Month #3, day 18 indicated the resident's Humulin R was delivered on that day.

The EMAR for Month #3, day 24 indicated the resident's weekly Ozempic dose was not administered as the resident refused the medication. However, there was no documentation Ozempic had been delivered in the preceding week.

The EMAR for Month #3, day 31 indicated the resident's weekly Ozempic dose was not administered as the medication was out of stock.

A review of the resident's pharmacy documentation did not indicate Ozempic was ordered or delivered in Month #3.

A review of the resident's progress notes in Month #3 lacked documentation regarding the missed doses of Ozempic or Humulin R insulin.

A review of the resident's medical record did not indicate the medical provider was notified of missed medication doses.

A review of the facility's medication error report log did not contain medication error reports for the resident in Month #3 containing corresponding dates for medications that were not administered.

Month #4
The EMAR for Month #4, day 7 indicated the resident's weekly Ozempic dose was not administered as the medication was out of stock, and indicated the nurse was notified.

The progress notes for Month #4, day 13 indicated the resident had an Endocrinology appointment during which the Ozempic dose was increased along with new orders to address high blood sugars. The same document indicated the resident's Basaglar insulin was discontinued.

The EMAR for Month #4, day 14 indicated the resident's weekly Ozempic dose was not administered as the medication was out of stock, and indicated the nurse was notified.

The EMAR for Month #4, day 21 indicated the resident's weekly Ozempic dose was not administered as the medication was out of stock, and indicated the nurse was notified.

The EMAR for Month #4, day 26 indicated the resident's Humulin R doses were not given. Documentation indicated needles were not available to administer the medication.

A pharmacy delivery record for Month #4, day 28 indicated the resident's Ozempic dose was delivered.

A pharmacy delivery record for Month #4, day 30 indicated the resident's pen needles were delivered.

A review of the resident's progress notes did not include documentation regarding missed doses of Ozempic or Humulin R for Month #4.

A review of the resident's medical record did not indicate the medical provider was notified of Month #4's missed medication doses.

The facility's medication error report log did not contain medication error reports for the resident in Month #4 containing corresponding dates for medications that were not administered.

Month #5

The EMAR for Month #5, day 15 indicated the resident's Humulin R doses were not administered because the medication was out of stock, the documentation also indicated the nurse was notified.

The EMAR for Month #5, day 16 indicated the resident's Humulin R doses were not administered because the medication was out of stock, the documentation also indicated the nurse was notified.

The EMAR for Month #5, day 17 indicated the resident's Humulin R doses were not administered because the medication was out of stock, the documentation also indicated the nurse was notified.

A pharmacy delivery record for Month #5, day 17 indicated R1's Humulin R was delivered on that day.

A review of the resident's progress notes did not include documentation regarding missed doses of Humulin R for Month #5.

A review of the resident's medical record did not indicate the medical provider was notified of Month #5's missed medication doses.

The facility's medication error report log did not contain medication error reports for the resident in Month #5 containing corresponding dates for medications that were not administered.

During an interview, a nurse stated she had been assigned to the resident shortly before the beginning of Month #1. The nurse stated the pharmacy dispensed insulin pens but did not dispense the inulin pen needles due to "state rules", however now the facility gets the needles from a different pharmacy. Regarding EMAR documentation, the nurse stated the unlicensed caregivers passing medications use an "automated snippet" when a medication is not given as ordered, however the nurse is not necessarily notified. The nurse stated the facility does not complete audits of the facility's EMARs and she was not personally involved in medication error reports.

During an interview, the resident stated the facility does not monitor his insulin supply and he seems to run out every other month.

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: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility sent the resident to the hospital on multiple occasions.

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:
Office of Ombudsman for Long Term Care
Office of Ombudsman for Mental Health and Developmental Disabilities
Scott County Attorney
Elko New Market City Attorney
Elko New Market Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30764	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON NATCHEZ	27890 NATCHEZ AVE ELKO, MN 55020

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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: #HL307649863C/#HL307646582M and HL307643263C/HL307647742M On February 25, 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 6 residents receiving services under the provider's Assisted Living license. No correction orders are issued for HL307643263C/HL307647742M. However, the following correction orders are issued for #HL307649863C/#HL307646582M: correction order identifications 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. 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.	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 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. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to document the reason medications were not given as prescribed and to document follow-up procedures to ensure the resident's needs were met for one of one (R1) resident reviewed. The licensee also failed to ensure a system was in place to identify, document, track, and evaluate medication errors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 facility on August 25, 2020, with a diagnosis that included insulin dependent	01760		

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01760	Continued From page 2 type 2 diabetes. R1's care plan dated February 5, 2025, indicated R1 required assistance with medication management and administration and blood glucose monitoring. R1's October EMAR indicated the licensee was to administer the following medications: Humulin R (short-acting insulin) inject 100 units three times daily Basaglar (long-acting insulin) inject 30 units twice daily Ozempic (a medication to lower blood sugar) 1 mg injected weekly The EMAR dated October 14 indicated R1's evening Basaglar dose was not given due to lack of needles to administer medication. The EMAR dated October 15 indicated R1's weekly Ozempic dose, Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 16 indicated R1's Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 17 indicated R1's Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 18 indicated R1's Humulin R doses to be given with meals and	01760		

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01760	Continued From page 3 Basaglar twice daily doses were not given due to needles not available to administer medication. The progress notes dated October 18, 2025, 7:34 p.m., indicated R1 was taken to the hospital for hyperglycemia. The same documented indicated this was treated and he returned to the facility the same day. The EMAR dated October 19 indicated R1's Humulin R doses to be given with meals three times daily and Basaglar twice daily doses were not given due to needles not available to administer medication. The EMAR dated October 20 indicated R1's Humulin R am dose and morning dose of Basaglar were not given due to needles not available to administer medication, the evening dose of Basaglar was initialed as administered to R1. The afternoon and evening doses of Humulin R indicated R1 was out of the facility. The EMAR dated October 21 indicated R1 was out of the facility for morning doses of Humulin R and Basaglar. The progress notes electronically signed on October 22, 2024, at 5:49 p.m., but dated for October 17, 2024, at 10:57 a.m., indicated R1 was out of supplies "non-wearable" diabetic supplies. The same document indicated the facility asked the medical provider to send a request to the local pharmacy. A review of the document did not specifically mention insulin pen needles for administration. The progress notes electronically signed on October 22, 2024, at 5:57 p.m., but dated for October 19, 2024, at 5:49 p.m., indicated the	01760		

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01760	Continued From page 4 local pharmacy could not fill order for test strips. A review of the document did not specifically mention insulin pen needles for administration. The progress notes electronically signed on October 22, 2024, at 6:01 p.m., but dated for October 20, 2024, at 5:58 p.m. indicated the facility attempted to purchase pen needles on October 19 unsuccessfully. The facility contacted their contracted pharmacy requesting pen needles for insulin administration be delivered ASAP. A review of the medical records for dates of October 19-21, 2024, did not identify documentation indicating the facility contacted the medical provider for an order for the pen needles. The progress notes electronically signed on October 22, 2024, at 6:05 p.m., but dated for October 21, 2024, at 12:02 p.m. indicated R1 was hospitalized on October 20, 2024, and was discharged back to facility with pen needles when he returned to the facility on October 21. The progress notes dated October 22, 2024, at 6:05 p.m. indicated R1 was again transferred to hospital for hyperglycemia. The progress notes on October 22, 2024, at 6:50 p.m. indicated the RN was updated on October 19, 2024, of the need to obtain insulin pen needles for R1. The resident returned to the facility on October 24, 2024. The facilities medication error report log did not contain medication error reports for R1 in October containing corresponding dates for medications	01760		

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01760	Continued From page 5 that were not administered. A review of R1's medical record did not indicate the medical provider was notified of missed medication doses in October. The EMAR dated November 12 indicated Ozempic dose was not administered and out of stock, nurse notified. A review of R1 progress notes for November did not indicate documentation regarding the missed dose. A review of R1's medical record for November did not indicate the medical provider was notified of missed medication doses. The facilities medication error report log did not contain a medication error report for R1 in November containing corresponding date for medications that were not administered. The EMAR dated December 3 indicated R1's weekly Ozempic dose was not given, medication was out of stock. The EMAR dated December 17 indicated R1's weekly Ozempic dose and evening meal dose of Humulin R was not given, medication was out of stock. The EMAR dated December 18 indicated R1's Humulin R noon and evening meal doses were not given as medication was out of stock. A pharmacy delivery record dated December 18 at 8:25 p.m. indicated R1's Humulin R was delivered.	01760		

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01760	Continued From page 6 The EMAR dated December 24 indicated R1's weekly Ozempic dose was not given, resident refused medication. The EMAR dated December 31 indicated R1's weekly Ozempic dose was not given, medication was out of stock. A review of R1 progress notes in December did not indicate documentation regarding the missed doses. A review of R1's medical record did not indicate the medical provider was notified of missed medication doses. The facilities medication error report log did not contain medication error reports for R1 in December containing corresponding dates for medications that were not administered. The EMAR dated January 7 indicated R1's weekly Ozempic doses were not given and out of stock with nurse notification. The progress notes dated January 13 indicated R1 had an Endocrinology appointment during which Ozempic dose was increased along with new orders to address high blood sugars. The same document indicated R1's Basaglar was discontinued. The EMAR dated January 14 indicated R1's weekly Ozempic doses were not given and out of stock with nurse notification. The EMAR dated January 21 indicated R1's weekly Ozempic doses were not given and out of stock with nurse notification.	01760		

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01760	Continued From page 7 The EMAR dated January 26 indicated R1's Humulin R doses, to be given with meals three times daily, were not given. Documentation indicated needles were not available to administer the medication. A pharmacy delivery record dated January 28 at 4:53 p.m. indicated R1's Ozempic dose was delivered. A pharmacy delivery record dated January 30 at 7:43 p.m. indicated R1's pen needles were delivered. A review of R1's progress notes did not include documentation regarding missed doses of Ozempic or Humulin R for January. A review of R1's medical record did not indicate the medical provider was notified of the January missed medication doses. The facilities medication error report log did not contain medication error reports for R1 in January containing corresponding dates for medications that were not administered. The EMAR dated February 15 indicated R1's Humulin R doses, to be given with meals three times daily, were not given as medication was out of stock and indicated nurse notification. The EMAR dated February 16 indicated R1's Humulin R doses, to be given with meals three times daily, were not given as medication was out of stock and indicated nurse notification. The EMAR dated February 17 indicated R1's Humulin R dose, to be given with the morning meal, was not given as medication was out of	01760		

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01760	Continued From page 8 stock and indicated nurse notification. A pharmacy delivery record dated February 17 at 11:00 a.m. indicated R1's Humulin R was delivered. A review of R1's progress notes did not include documentation regarding missed doses of Humulin R for February. A review of R1's medical record did not indicate the medical provider was notified of the February missed medication doses. The facilities medication error report log did not contain medication error reports for R1 in February containing corresponding dates for medications that were not administered. On March 13, 2025, at 2:45 p.m. during a phone interview, nurse-C stated she had been assigned to the resident shortly before the beginning of Month #1. Nurse-C stated the pharmacy dispensed insulin pens but did not dispense the insulin pen needles due to "state rules", however now the facility gets the needles from a different pharmacy. Regarding EMAR documentation, nurse-C stated the unlicensed caregivers passing medications use an "automated snippet" when a medication is not given as ordered, however the nurse is not necessarily notified. Nurse-C stated the facility does not complete audits of the facility's EMARs and she was not personally involved in medication error reports. The facility's policy and procedure titled "Medication and Supplies reordering" dated 9/23/2020, indicated the staff of The Lodges Company will assist residents to make sure medications and supplies are ordered and	01760		

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(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
01760	Continued From page 9 available as needed. The facility's policy and procedure titled "Medication errors" dated 9/23/2020, indicated the staff of The Lodges will document, track and resolve medication administration errors for quality improvement and to follow proper procedures. The facility's policy and procedure titled "Insulin" dated 9/23/2020 indicated only properly trained staff of The Lodges Company may provide medication assistance or administration. Insulin medications must be administered according to the prescriber's orders. Time period for correction: Seven (7) days.	01760		
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(s) 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	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30764	A. BUILDING: _____ B. WING _____	C 02/25/2025

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02360	Continued From page 10 details.	02360		