Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL288962183M
Compliance #: HL288963735C

Date Concluded: September 9, 2025

Name, Address, and County of Licensee Investigated:
Sugar Loaf Senior Living
765 Menard Rd
Winona, MN 55987
Winona County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Not Substantiated

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 facility failed to implement a new medication order.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the medication change did not get implemented on the date ordered, when the hospice order was located, the medication was ordered from the pharmacy and administered albeit it was delayed.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the hospice agency and a family member. The investigation included review of the resident record(s), progress notes, provider and hospice orders, facility internal investigation, facility medication incident reports and related facility policy and procedures. Also, during an onsite visit the investigator observed where the fax/copy machine was located.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, automatic implantable cardioverter defibrillator pacemaker, and chronic kidney disease. The resident was on hospice care. The resident's service plan included monthly vital signs and weight, oxygen management, compression stockings, toileting assistance, medication management, and transfer assistance.

The resident's assessment indicated the resident is alert, oriented, and has poor short-term memory. The resident has edema related to his diagnosis and is prescribed medication to help remove the excess fluid. The resident does experience shortness of breath supplemented with continuous use of oxygen via nasal cannula and oxygen through his continuous positive airway pressure (CPAP) machine at night. The resident was enrolled in hospice, which ordered medication order changes.

A concern arose the resident did not receive his medications as ordered. Hospice ordered a medication, a diuretic, to address the resident's fluid retention on a Friday. However, the medication was not administered until Tuesday.

A review of the process for medications indicated hospice orders were sent to the pharmacy and the then the pharmacy entered those orders into resident's electronic medication administration record (EMAR) for the facility. Those orders were then reviewed by a facility nurse and confirmed in the EMAR.

The facility's internal investigation indicated hospice ordered a change in medication however, the resident's medical provider was not available to sign the order, and so hospice requested a signature from another provider which took additional time to obtain. Later the same day and once the change in medication order was signed, hospice faxed the order to the facility. This visit and change of order occurred on a Friday of a holiday weekend.

The EMAR indicated the increase of medication was for three days only in the mornings. The same document indicate it was entered into the EMAR with an effective date on the following Tuesday, Wednesday, and Thursday. The EMAR indicated the medication was given as ordered although a few days later than originally intended by hospice.

During an interview, a nurse, who is also a manager, stated she was reviewing a large amount of paperwork from the facility fax/copier machine related to a possible new admission and found the hospice order in that paperwork but not until the next day (Saturday) however she was at a location without a fax and the pharmacy was not open on Sunday. The order was submitted to the pharmacy on Monday however deliveries from the pharmacy do not come until evening so the medication was started the next day, Tuesday.

The nurse stated the pharmacy is responsible for adding medication changes to each resident's electronic medical record and, when that occurs, an icon comes up in the electronic medication record software to alert the nurse and the nurse clicks on that to confirm or acknowledge the

medication changes. The nurse stated on that day, a Friday, the hospice nurse was at the facility however there was no communication when she left to indicate there would be a change in medication.

During an interview, a hospice nurse stated it was not unusual to order a short burst of a diuretic during times of increased fluid retentions, increase shortness of breath or other changes of symptoms related to the heart failure. The hospice nurse stated the process for medication changes was for hospice to fax the signed order to the facility and them facility was responsible for sending the order over to the pharmacy. The nurse stated the new order required a physician's signature which took a little longer as the primary provider was not available. The facility was aware the resident was visited by hospice, however, when leaving the facility, the hospice nurse was unable to locate a staff member to report off to. She stated she saw the resident at approximately 3 p.m. on that Friday.

A review of the resident's medical record did not indicate the resident required medical attention nor hospitalization as a result of the delay.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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, the resident was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The facility's changes included a discussion with hospice for them to fax orders to the pharmacy as well as the facility. The facility will follow up the pharmacy to ensure order was received and ensure that order has been placed on the resident's electronic medication record. The facility reinforced with staff members to monitor the copier/fax and any documents not theirs are placed in a hanging wall file for departments to look through to

ensure they receive. Hospice will also verbalize to the nurse at the facility any significant medication changes or order changes.

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
	28896	A. BUILDING: _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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 June 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL288963735C/#HL288962183M. No correction orders are issued.	0 000		