Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL290882322M
Compliance #: HL290884008C

Date Concluded: June 16, 2025

Name, Address, and County of Licensee Investigated:
Valentines of Lake City
317 North High Street
Lake City, MN 55041
Wabasha County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 staff failed to assess the resident following a fall that resulted in a fractured hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident sustained an unwitnessed fall. Following the fall, the resident was assessed by the facility nurse and later in the day the resident's pain increased, and the resident was sent to the hospital for an evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and osteoarthritis of the knee. The resident's service plan included assistance with walking. The resident's assessment indicated the resident required assistance with transfers, toileting, and walking. The resident's assessment indicated the resident used a wheelchair as needed for mobility, had cognitive impairment, and used pain medications three times a day for back and shoulder pain.

The facility incident report indicated the morning of the incident the resident was found on the bathroom floor. Staff observed the resident's left side with no injuries. The resident stated she had left knee pain. Staff performed a two person transfer of the resident into her wheelchair and completed cares. The incident report indicated the resident often complained of general pain and could not specifically identify if the pain was from the fall. The resident was able to transfer with no issues.

Progress notes indicated the resident received cares approximately 45 minutes prior to being found on the floor. Approximately one hour after the resident the fell, a facility nurse assessed the resident. The resident was able to stand up with her walker and perform range of motion. The resident reported that she always had pain but felt fine. The resident was found with no injuries. Staff were educated to notify the nurse if the resident was observed with any bruises or pain. The progress notes indicated seven and half hours after the nurse assessed the resident, the nurse received a phone call from a staff member. The resident was unable to stand and was complaining of pain. The resident was transferred to the hospital for an evaluation.

Hospital records indicated the resident slipped and fell. The resident had increasing pain over the day, became less active, and unable to bear weight. The resident sustained a non-displaced (a broken bone where the pieces remain aligned) left hip fracture. The resident discharged from the hospital to a different facility that could provide the resident with a higher level of care.

During an interview, unlicensed staff member stated after the resident fell, she was assisted off the floor and into her wheelchair. The resident came out to the dining room for breakfast. At lunch time the resident ate lunch in her room. Following lunch, the resident was assisted to the bathroom. The resident did not complain of pain while being assisted to the bathroom.

During an interview, leadership stated the day of the resident's fall, overnight staff had assisted with cares early in the morning. Then about 45 minutes later the day shift staff went into the resident's room to assist with getting up for the day. The staff member found the resident on the floor in her bathroom. Leadership stated they were notified of the resident's fall that morning as they were on their way into the facility. Once leadership arrived at the facility, the resident was assessed, and range of motion was completed with the resident. The resident had no injuries at that time and the resident was at her baseline for pain. Leadership stated in the

afternoon staff had notified them that the resident was having increase pain, and the resident was sent to the hospital for an evaluation.

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 no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Following the resident’s fall, the resident as assessed by a nurse and instructions to call the nurse if the resident had bruises or increased pain were provided to the staff. Once it was determined the resident had increase pain, the resident was sent to the hospital for an evaluation.

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
	29088	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALENTINES OF LAKE CITY, INC	317 NORTH HIGH STREET LAKE CITY, MN 55041

(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 4, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL290882322M/#HL290884008C. No correction orders are issued.	0 000		