Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308182342M
Compliance #: HL308184127C

Date Concluded: May 24, 2023

Name, Address, and County of Licensee Investigated:
Guardian Angels by the Lake
13439 185th Lane northwest
Elk River, MN 55330
Sherburne County

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

Evaluator's Name: Willette Shafer, 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 a resident when the facility locked a resident in their room and failed to provide supervision to keep the resident safe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided care and supervision according to the resident's care plan and the resident was able to move freely from the inside even when the resident's door was locked from the outside to prevent other residents from wandering in.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, family, and the hospital social worker. The investigation included review of resident's medical record, personnel files, incident reports, and facility policies. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, hallucinations, anxiety, and depression. The resident's service plan included assistance with medication management, dressing, grooming, bathing, toileting, meals, activity reminders, and housekeeping. The resident's assessment indicated the resident was cognitively impaired and had aggressive behaviors towards staff.

During an interview, the family stated the resident was locked in her room during the day, as the resident was unaware of how to turn the doorknob. The family member stated the facility should have recognized the resident had an infection earlier.

According to the progress notes, the resident was sent to the hospital for an unrelated medical issue four days prior to the incident. The hospital record lacked documentation for concerns of an infection. The next day, the RN assessed the resident and there was no documentation of infection concerns at that time.

The progress notes on the day of the allegation indicated a staff member noticed a change in condition during morning cares and alerted the nurse immediately. Nurse 2 assessed the resident and called for emergency medical services immediately.

During an interview, nurse 2 stated a staff member reported the resident had a change in condition. Nurse 2 assessed the resident and found the resident was in distress, vitals were abnormal, and the resident's neck was distended and tender to touch. Nurse 2 called emergency medical services and transported the resident to the hospital. The resident was diagnosed with an infection. Nurse 2 stated the resident was able to open the door to her bedroom to get out of her room.

During an interview, a staff member stated she observed a change in condition in the resident during morning cares and alerted nurse 2. The staff member stated the resident's door was closed at times so other residents could not wander in. The staff member stated she had observed the resident walking in and out of her door when the door was closed.

During an interview the hospital social worker stated the resident was diagnosed with an infection, was treated, and discharged on hospice to a nursing home for higher level of care. The social worker stated there were no concerns of care related to the facility.

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, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility followed their policy for medical emergency when the resident had a change in condition. The facility had meetings with family to discuss the resident's care plan.

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
	30818	A. BUILDING: _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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 May 12, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL308184127C/#HL308182342M. No correction orders are issued.	0 000		