Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308189782M
Compliance #: HL308189341C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Guardian Angels By the Lake
13439 185th Lane Northwest
Elk River, Minnesota 55330
Sherburne County

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

Evaluator's Name: Nicole Myslicki, 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 alleged perpetrator (AP) neglected the resident when the AP failed to complete the resident's scheduled service one evening. Staff found the resident deceased the next morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP failed to complete a scheduled service the night before the resident was found deceased, there is no evidence to demonstrate failing to complete the service played a role in the resident's death. There was not a pattern of error for the AP to miss providing services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel file, staff schedules, law enforcement report, related facility

policy and procedures. Also, the investigator observed the floor plan of the apartments, as well as services and how they are documented.

The resident resided in an assisted living facility. The resident's diagnoses included plaque buildup in the arteries, kidney disease, and high blood pressure. The resident's service plan included assistance with compression socks and a daily safety check at 11:30 a.m. The resident's assessment identified the resident as independent with moving around in his apartment and medication administration. The assessment also indicated the resident needed assistance to pull on and remove his compression socks, as well as cleaning the socks daily.

The resident's service delivery record indicated the facility added the service of putting on compression socks daily at 8:00 a.m. and taking them off at 8:00 p.m. The AP signed off she removed the resident's compression socks and washed them the night before being found deceased.

The resident's death record identified the resident's cause of death as plaque buildup in the arteries.

A law enforcement report indicated staff found the resident on the floor, unresponsive and cold to the touch. Law enforcement observed the resident laying on the floor along the right side of the bed, laying face down. He wore a red, short-sleeve shirt and underwear. A black shoe was located on the floor near his left knee. There was a pile of worn clothing on the floor at the corner of the dresser in the bedroom, about one foot away from his head. The pile included a pair of blue jeans, shirt, and socks. Law enforcement touched the resident who was cold to the touch and rigor had set in at his neck. Upon closer inspection, law enforcement observed lividity had settled in the bottom portions of his body, neck, face, and right arm. A patch of skin on his back was scraped. Law enforcement inspected his body and found no signs of trauma or anything suspicious. The resident's weekly pill container had all the slots filled except for the morning and evening compartments for the day of the incident. The law enforcement report included an interview with the resident's family member. The family member stated the resident's health had recently been declining. Family last spoke with the resident around 7:00 p.m. the night before he had been found deceased.

Photographs taken by law enforcement showed the resident on the floor of his apartment between the bed and wall, in front of his nightstand. The resident had not been wearing socks, but a pair laid on the floor with his pants and shirt. The photographs also showed the resident's weekly pill container with every morning and evening compartment filled with medications except the morning and evening of the incident.

The facility completed an internal investigation of the incident. The investigation included review of video footage and interviews with staff. The investigation indicated the resident requested a dinner tray the evening before being found deceased. Unlicensed personnel (ULP)-4 answered the resident's call stated the resident seemed normal. A dietary staff member

delivered the resident's tray about half an hour after requesting the tray. The next morning, a dietary aide retrieved the dinner meal tray which had been placed outside the resident's apartment door. The dietary aide did not enter the resident's apartment the morning of the incident. Unlicensed personnel (ULP)-1 entered the resident's room at 8:34 a.m. but did not see the resident, and she left the apartment. The resident did not require escorts to meals. ULP-1 re-entered the resident's apartment at 10:29 a.m. and again did not see the resident. Family then called the facility, asking for someone to check on the resident. ULP-1 entered the apartment a third time and then found the resident. ULP-1 called for a nurse over the walkie system, and ULP-2 and ULP-3 responded. ULP-2 called 911, and ULP-3 called the nurse on call. The investigation included an interview with the AP, during which the AP stated she did not enter the apartment as scheduled and signed off on the service check off list. The investigation also included an interview with ULP-1. ULP-1 stated the resident had a service to put on his compression socks at 8:00 a.m. ULP-1 entered the apartment, checking his room, living room, bathroom areas. She also called for him a couple of times but received no response. ULP-1 assumed the resident had gone to breakfast and finished up with other residents' medications and cares. About an hour and a half later, ULP-1 went back to the resident's apartment and checked the same areas. When she did not see the resident, she thought he may be at an activity. ULP-1 went to finish laundry, when ULP-2 asked her to check on the resident due to family wanting them to check on him. ULP-1 went to the resident's apartment again, this time walking around the bed, and found him. The resident had been quite independent, so not escorting him or providing cares in the morning seemed to fit his capability level.

During an interview, ULP-2 stated she responded to ULP-1 requesting a nurse over the walkie system. ULP-2 called 911. She touched the resident who felt cold and had a purplish color. The resident did not appear entrapped but looked to be in almost a fetal position with his arms wrapped under him. ULP-2 stated the resident did not report any feelings of the resident being unwell in the days prior to the incident.

During an interview, ULP-3 stated she also responded to the call over the walkie system requesting a nurse. ULP-3 observed the resident. She did not touch the resident, but there were no signs of breathing, and his limbs were blue. The resident looked like he had maybe been going to bed or getting out of bed. From the kitchen area of the apartment, the resident could not be seen where he laid, between his bed and the window.

During an interview, a nurse stated she received a call the resident died unexpectedly. The nurse arrived at the facility, but law enforcement had arrived first, so she could not enter the resident's apartment. The nurse began an investigation into the incident. After law enforcement cleared the scene, the nurse went into the apartment. She could not see the resident until she started walking around the bed, then she observed the resident on the floor, on the far side of his bed. A law enforcement officer told the nurse it looked as if the resident had been sitting on his bed and just collapsed. The nurse stated it appeared to have happened suddenly. Even if ULP-1 had found him the first time she went in that morning, it would not have made the difference.

During an interview, the AP stated she did not see the resident the evening she worked, though he had been on her group. The resident had been fairly independent and did not require many services. The AP stated she did not complete the service of removing his compression socks. The AP stated she had several services at the same time. She removed another resident's compression socks and may have gotten confused when marking off service completion in the charts.

During an interview, the resident's family member stated they thought the resident received great care at the facility. Prior to the incident, the resident had been having a hard time walking, and they were in the process of having him assessed to see what other services he may need.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by the facility. The facility completed education with staff regarding completing and documenting services.

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 05/05/2025

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 5, 2025, the Minnesota Department of Health initiated an investigation of complaint HL308181742M/HL308182927C, HL308181862M/HL308183190C and HL308189782M/HL308189341C. No correction orders are issued.	0 000		