Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:
HL308181742M, HL308181862M
Compliance #: HL308182927C, HL308183190C

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 facility neglected the resident when the resident sustained several injuries to his toes which required treatment and antibiotics. Also, the facility neglected the resident when the resident fell several times in less than one month. The resident sustained a head injury and skin tear.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated related to both allegations. Although the resident developed wounds to his toes, evidence did not show the development was caused by the facility not providing cares or services to the resident. Additionally, there was no evidence to show the facility not providing cares, services, or supervision led to his falls.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, hospital and clinic records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed transfers, medication administration, and toileting.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and diabetes. The resident's service plan included assistance with medication administration, skin monitoring, escorts, dressing and grooming, transfers, and walking.

The resident's service delivery records indicated the resident received services throughout the day, including toileting, transferring assistance, reassurance checks, and dressing and grooming. The resident often refused or self-completed services such as toileting, dressing, and transferring.

The facility completed an admission assessment the day the resident moved in. The assessment indicated the resident previously lived with a family member. The assessment indicated the resident had no identified risk factors for skin integrity problems. The assessment also identified the resident as independent with walking, transfers, and nail care, and as needing verbal reminders for grooming and oral care. The assessment also identified the resident needed assistance with toileting as needed. The fall risk portion of the assessment identified the resident as not at risk for falling, but the facility did include a fall reduction plan with interventions to help prevent falls. The assessment also indicated the resident did not require safety checks and identified the resident as independent with the call light system. The assessment also indicated the nurse completing the assessment spoke with the resident's family members. Family stated the resident often required reminders with things like grooming, oral cares, dressing, putting on and removing hearing aids. Family stated the resident needed physical assistance with bathing, toileting and assistance ensuring a new brief was put on and a soiled brief was removed and thrown in the trash. Family also stated the resident walked independently with a walker.

Three days later, the facility completed another assessment. The assessment identified the resident's cognition as being worse than initially assessed. The resident required assistance of one staff member for all cares due to poor cognition and an inability to follow simple instructions without hands-on assistance.

Three and a half weeks later, the facility completed a third assessment. The assessment indicated the facility added the services of a nurse to complete nail care due to the resident's diabetes diagnosis and escorts to activities.

The same day, an incident report indicated the resident self-reported a fall. The resident had a cut on his lip and dried blood on his nostrils. The resident got himself up from his living room floor. A nurse assessed the resident and reviewed the service plan.

Three days later, a progress note indicated staff observed a black toenail on the resident's left foot. The next day the nurse assessed the resident's feet. The nurse observed a small open area on the second toe on the right foot and scabbed over areas on the second and third toes of the left foot. The facility requested an order for home care and cleansed the wounds.

An incident report indicated the resident had a second unwitnessed fall, four days before the resident discharged from the facility. The resident had been found on the floor, calling out for a family member. He fell trying to get out of bed. Staff obtained vitals and assisted the resident off the floor.

One week later, the resident saw podiatry. The podiatrist's note indicated their findings were consistent with vascular compromise (a condition where blood flow to a specific area is reduced, potentially causing tissue damage or death). The resident had superficial wounds on three of his toes.

Several progress notes indicated the resident received wound care from home care nurses and from facility nurses.

About six weeks after admitting to the facility, the resident discharged back home with his family member, with the reason for discharge being family preference.

During an interview, a nurse stated the resident started out receiving reminders for many services but then changed him to physical assistance. The resident often transferred independently, though they identified him as needing assistance due to being unsteady on his own. During an initial assessment, the resident's family member let the staff know he needed reminders for a lot of things but could walk and stand independently. After the resident lived there for a few days, the facility had to reassess him because he had not been as capable as they initially thought when he moved in. The facility added more hands-on services at that time. A few weeks after moving in, the facility noticed some wounds on his toes. The facility addressed the wounds and requested orders for home care orders and had podiatry see him. After some time, the resident's family declined for home care to address the wounds. The nurse did not know what caused the wounds but suspected they were rubbing inside his shoes. One toe looked to have been rubbing against another toe, and one foot had scabbed over areas on the top sides of his toes near the toenails. The resident had also been incontinent, and there were times they had to wash his shoes because they smelled of urine. During his stay, the resident had two falls. Regarding the first fall, the resident reported he fell during the night but got himself up. Staff cleaned him up and instructed him to let them know if he had any pain. Regarding the second fall, the resident slid out of bed trying to get up. Staff found him lying on the floor, calling out for a family member. The resident did not have injuries from that fall. Staff instructed the resident to ask for help before transferring, but he self-transferred a lot.

During an interview, the resident's family member stated the resident stayed at the facility for about six weeks. During that time, the resident had falls and developed sores on his feet. One of the falls occurred a couple of days before he discharged back home with her. The family member decided to bring the resident back home with her.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed the resident after his falls. The facility requested podiatry and home care for the wounds on his toes.

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		