Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308189203M
Compliance #: HL308183126C

Date Concluded: February 23, 2026

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

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

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Inconclusive

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), a licensed nurse, neglected the resident when the AP did not perform cardiopulmonary resuscitation (CPR) when the resident passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It was unable to be determined if the resident's death could or could not have been prevented by initiating CPR. The AP found the resident without a pulse for an unknown amount of time and did not provide emergency intervention measures because the resident's Physician Orders for Life Sustaining Treatment (POLST) form contained conflicting instructions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's family. The investigation included review of the resident records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, law

enforcement report, and related facility policy and procedures. Also, the investigator observed the room and the location of the resident's passing.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (CHF) and hypertension (high blood pressure). The resident's service plan included assistance with safety checks once daily. The resident's assessment indicated independence with most activities of daily living, ability to make needs known and had a signed POLST by the primary care provider.

The internal investigation indicated the resident reported to an unlicensed staff that she was not feeling well and requested the unlicensed staff to notify a family member. The unlicensed staff reached out to family for the resident. The unlicensed staff left the room to assist another resident and when they returned, the resident was found struggling to breathe. The unlicensed staff requested assistance from a licensed staff member. Licensed staff found the resident gasping to breathe, excess secretions around the resident's mouth, and directed the unlicensed staff to remain with the resident. The licensed staff left the resident's room to call 911 and to locate the resident's code status. The internal investigation indicated when licensed staff were on the phone with 911, the AP entered the facility, was told 911 was on the phone and assistance was needed in the resident's room. The AP went to the resident's room, directed unlicensed staff to lay the resident flat on the bed, and the AP identified the resident was deceased.

The medical record indicated AP found no signs of life and the resident was identified as deceased. The AP notified the licensed staff on the phone with 911 that the resident was deceased and family was notified. The resident's medical record indicated the AP did not perform cardiopulmonary resuscitation (CPR) because the resident was found deceased.

The resident's POLST indicated the resident wanted CPR. The resident POLST identified that the resident did not want "Full Treatment." The resident's POLST identified that the resident did not want measures to be taken if an event led to an intensive care unit, intubation, or advanced airway interventions.

The law enforcement report indicated the officer conducted a death investigation and found no signs of foul play.

The resident's death certificate listed natural causes as the cause of death.

During an interview, unlicensed staff stated the resident summoned her, she went to the resident's room, and the resident was not out of bed yet, which was unusual for the resident. The resident reported not feeling well, had coughed all night and asked if she would call family for her. The unlicensed staff left the room and was summoned again by the resident. The resident had secretions coming from her mouth, it appeared as if the resident was choking. A

licensed staff entered the room and advised to unlicensed staff to stay with the resident. The AP arrived and advised to lay the resident down because she had passed.

During an interview, a licensed nurse stated an unlicensed staff came and reported staff needed assistance with the resident. An unlicensed staff was holding the resident in an upright position. The resident had agonal breathing (often indicates severe distress or impending death), secretions from the mouth and unresponsive. The unlicensed staff was instructed to remain with the resident, and a licensed nurse went to call 911. He was on the phone with 911 when the AP entered the facility. The AP went to the resident's room and returned reporting the resident had passed.

During an interview, the AP stated a licensed nurse advised the resident needed assistance. When she entered the resident's room, she observed unlicensed staff holding the resident in an upright sitting position and the resident's skin color indicated the resident was deceased. She directed the unlicensed staff to lay the resident down. Heavy secretions were observed on and around the resident's mouth and chest, gray skin coloring, fixed open eyes and a pulse or heartbeat could not be found. The resident's POLST indicated she wanted CPR; however, CPR was not initiated because she did not know how long the resident was deceased. The AP stated the POLST form was conflicting, and family was aware.

During an interview, a family member stated there were no concerns with cares the resident received at the facility and no issues with how the incident was managed.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes

Action taken by facility:
The facility called 911 and reviewed with all residents their advance directives for accuracy and clarity.

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 01/27/2026

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 January 27, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL308189203M/#HL308183126C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	