Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318765922M
Compliance #: HL318768581C

Date Concluded: December 24, 2024

Name, Address, and County of Licensee Investigated:
Elysian Senior Homes of Lake City
480 W. Grant Street
Lake City, MN 55041
Goodhue County

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

Evaluator's Name: Deb Schillinger 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 it did not identify he had left hand pain, which turned out to be a skin infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident first informed a family member of his hand pain and she subsequently informed the nurse, the facility took appropriate action once the concern arose and the resident received antibiotics. Several days after the antibiotic was completed, the cellulitis recurred. Again, the facility needed to be alerted, However, once notified they recommended appropriate treatment which led to a hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a recent stroke and dementia. The resident's service plan included assistance with medication management and administration. The resident's assessment indicated he needed reminders at times but was mostly independent with his personal cares.

The progress notes indicated a family member contacted the facility because the resident's left wrist was painful during a visit on the previous day. A progress note time stamped around 1:30 PM that same day the facility nurse assessed the resident's wrist which was sore and slightly reddened but with range of motion intact. The nurse updated the family and formed a plan for the resident to see the medical provider the next day. However, the family member called back and said she would take him that same day.

Around 3:00 PM, the emergency room records indicated the resident had left wrist pain with intact range of motion with redness. The same documents indicated X-rays ruled out fractures although there was a possibility of cellulitis and was prescribed an antibiotic.

At approximately 4:30 PM the facility progress notes indicated the resident returned from the emergency room accompanied by the family member. The same document indicated the family member informed the facility the resident's X-rays were normal, but he may have cellulitis.

The resident's electronic medical record indicated the facility began administering the prescribed antibiotic the next day and continued for seven days.

Eleven days after the antibiotics were completed, the resident's progress notes time stamped around 10:30 AM indicated the resident again reported increased pain as reported by an unlicensed caregiver and a family member. The facility nurse assessed the resident's hand and found it to be reddened, swollen, and painful to touch. The nursed called the family member back, who said she would take the resident to see a medical provider. A progress note timestamped later that afternoon indicated the family member arrived and transported the resident to the emergency room.

The emergency room documents indicated the resident had recurring cellulitis and was admitted to the hospital. The hospital records indicated the resident's wrist pain continued but appeared to be improving with a new round of antibiotics. The resident continued to deny complaints regarding pain and symptoms to hospital nurses and later reported discomfort to the family member. The same documents indicated the resident had a recent blood draw for laboratory testing taken from the area around the site of the cellulitis, indicating a possible source of the original infection.

Upon discharge from the hospital the resident returned to the facility.

During an interview, a nurse stated during her assessment of the resident's left hand, she did not notice scratches or apparent injury noted to the residents left hand or wrist area, nor was the nurse notified of a report of injury. The nurse stated the resident had cognitive issues after a recent stroke but continued to be independent with personal cares. The resident was able to make his needs known, however, had not reported pain to unlicensed caregivers or the nurse(s) .

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required

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
	31876	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE CITY	480 WEST GRANT 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 December 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL318768581C/#HL318765922M. No correction orders are issued.	0 000		