DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL335244582M **Date Concluded:** November 7, 2025
Compliance #: HL335249267C

Name, Address, and County of Licensee Investigated:
The Moments of Lakeville
16258 Kenyon Avenue
Lakeville, MN 55044
Dakota 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 catheter care, skin monitoring and bathing was not provided. As a result, the resident was hospitalized with a UTI infection and later died.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility followed their Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) and provided the appropriate services to the resident. The home health provider, a provider separate from the facility, was notified of catheter issues and changed four times in the last twenty-four days the resident resided in the facility, exceeding the orders to change every 3-4 weeks as provided by the urologist.

Additionally, no notes or reports from the facility nor the home care provider indicated skin breakdown or wounds were present.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, home health care records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and facility staff interactions during an onsite visit.

The resident resided in a secured assisted living memory care unit. The resident's diagnoses included progressive dementia, history of bladder cancer, urinary retention, chronic atrial fibrillation (a heart rhythm disorder where the upper chambers of the heartbeat irregularly and rapidly) and took a medication to thin his blood. The resident had a home health provider to manage is urinary catheter. The resident's service plan included reporting any urinary catheter leaking, pain, concerns and catheter care including cleansing, emptying and changing the catheter bag. The same service plan included safety checks every two hours by facility staff to anticipate needs and provide support. The resident's assessment indicated the resident was oriented to person and walked using a walker.

A concern arose the facility did not have trained caregivers to manage the resident's urinary catheter, complete skin checks or bathe the resident.

The facility UDALSA indicated care of the catheter would be coordinated with and managed by the home health provider elected to provide skilled nursing care, but the facility caregivers could empty and change the catheter bags.

Catheter care orders provided by the urologist indicated the order to change the urinary catheter every 3-4 weeks. The resident's medical record indicated the urinary catheter had been changed twice in the 18 days following the order.

Progress notes indicated the resident's pulled out his urinary catheter four times in the twenty-three days before the resident was transferred to the hospital. The last time was on the day before the resident was transferred to the hospital.

The medical record indicated signs and symptoms of the urinary catheter not functioning properly all four times the device was pulled and required the home health provider to reinsert the urinary catheter after the resident pulled out the catheter. The common theme of the incidents were statements from the resident needing to urinate, increased anxiety, and blood or blood clots in the catheter tubing, indicating a catheter disfunction.

The day before the resident was sent to the hospital, progress notes indicated the resident had demonstrated increased agitation and had pulled out the catheter. The progress note indicated there was blood and blood clots in the catheter bag and the catheter was removed, the home health care provider and power of attorney (POA) were notified. The progress note indicated the POA declined to send the resident to the hospital. The home health care provider reinserted the urinary catheter in the early afternoon that same day.

Later that day, the resident became increasingly weaker, falling asleep during the evening meal, and with ongoing anxiety and agitation, stating “I want to rip this thing out”. The progress notes indicated that through the night the resident experienced at least two episodes of vomiting. By the next morning, staff reported an ongoing decline and reported a change in condition to the facility nurse. EMS was contacted after the POA agreed to send the resident to the hospital.

During an interview, an unlicensed caregiver who regularly was assigned to provide care to the resident, stated the resident was at his baseline condition on the day before he was transferred to the hospital. The unlicensed caregiver reported the resident was cooperative during the day shift, however it was reported he could be less cooperative during the evening shifts. The unlicensed caregiver reported he had assisted the resident to shower the day before and he did not notice skin breakdown during the shower. On the day the resident was transferred to the hospital, the unlicensed caregiver stated during the start of shift report he was told the resident had nausea and vomiting the previous shift and was weaker and more lethargic than the day prior. The unlicensed caregiver went on to state when he first checked on the resident, the resident was not responding as usual and was making a moaning sound. He stated he immediately alerted the facility nurse, who notified the family and EMS was called.

During an interview, a facility nurse reported when a resident has a urinary catheter, a home health care provider manages the urinary catheter because the assisted living facility does not provide skilled nursing services. The assisted living staff can only provide assistance for catheter care including cleansing, emptying and changing the catheter bag. When concerns or issues present with the resident’s urinary catheter, the facility nurse would notify the home health provider.

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 was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable the

Action taken by facility: The facility nurse notified the home health provider and POA with concerns. EMS was called when the resident's condition changed.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: ______ B. WING ______	C **09/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	**16258 KENYON AVENUE** **LAKEVILLE, MN 55044**

(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 September 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL335249267C/#HL335244582M. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE