Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350526682M
Compliance #: HL350521012C

Date Concluded: January 8, 2025

Name, Address, and County of Licensee Investigated:
Pelican Landing Senior Living
1325 Pelican Lane
Detroit Lakes, MN 56501
Becker County

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

Evaluator's Name: Barbara Axness, 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 it failed to provide adequate supervision. The resident wandered into another resident's room and drank unsecured dish soap. The resident was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was hospitalized after drinking dish soap, the error was an isolated incident and the resident returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the primary care provider. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, staff schedules, and related facility

policies and procedures. Also, the investigator observed the room where the resident consumed the dish soap.

The resident resided in an assisted living memory care unit. The resident's diagnoses included severe late Alzheimer's disease with agitation and chronic kidney disease. The resident's service plan included assistance with all activities of daily living, behavior management, routine safety checks, and medication administration. The resident's assessment indicated the resident had a history of wandering and a previous elopement from the facility. The resident had a history of verbal and physical aggression and resistance toward care. The resident had impaired cognition with poor decision making and required supervision.

The resident's medical record indicated the resident wandered into another resident's room and drank dish soap that was on the counter of the kitchenette. Staff immediately contacted the nurse who came to the facility and assessed the resident. The resident's primary care provider was notified, and poison control was contacted. At the direction of the primary care provider and poison control, the facility increased monitoring of the resident. The resident's responsible party declined an emergency room evaluation. Two days after ingesting the dish soap, the resident was observed to have a hoarse voice and sore throat with a decreased appetite and the primary care provider was updated. The next day, the resident was observed to be more tired and lethargic and had a hard time swallowing. The primary care provider was updated again, and an x-ray and lab work were ordered. The primary care provider assessed the resident at the facility and sent the resident to the emergency room for evaluation.

Hospital records indicated the resident was admitted with aspiration pneumonia, an acute kidney injury, and accidental poisoning by soap products. The resident spent two days in the hospital before he was discharged back to the assisted living facility.

During an interview, facility nursing staff stated as soon as they were notified of the resident drinking the dish soap, they took steps to ensure soap and other chemicals were more securely stored.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the incident to MAARC. The facility directed staff to ensure caps on soap bottles were secured tightly.

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
	35052	A. BUILDING: _____ B. WING _____	C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN LANDING SENIOR LIVING	1325 PELICAN LANE DETROIT LAKES, MN 56501

(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 17, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL350526682M/#HL350521012C. No correction orders are issued.	0 000		