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 #: HL305682342M
Compliance #: HL305681407C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:
Lakeview Assisted Living
941 10th Street
Heron Lake, MN 56137
Jackson County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 facility staff delayed medical care following an acute change in condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility nursing staff failed to assess the resident after staff reported a change in the resident's condition, resulting in a delay of care. The resident was unable to stand or bear weight on their left leg and remained in severe pain for over eight hours until family arrived at the facility and had the resident transported to the hospital. The resident was diagnosed with a hip fracture that required surgical intervention and transported to another hospital that provided a higher level of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

hospital records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed resident and staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and insomnia. The resident's service plan included reminders for dressing and grooming, safety checks, toileting, and medication management. The resident's assessment indicated the resident was independent with transfers and walking, did not use a wheelchair, was not at risk for falls, and did not have a history of pain. The assessment indicated the resident had severe cognitive impairment.

The morning of the incident the resident complained of leg pain and was unable to stand or walk. Unlicensed personnel (ULP) contacted the on-call nurse and staff were instructed to monitor the resident and call the family to see if they wanted the resident sent to the hospital. ULP called and left a message with a family member of the resident.

The resident remained in a recliner in her room as she was unable to walk or bear weight due to the pain. The nurse on-call did not call the facility back to follow-up on the resident's condition, did not contact the registered nurse (RN) to assess the resident, did not instruct ULP on how they should care for or transfer the resident, did not contact a medical doctor regarding the change in condition, and did not provide staff with direction on what to do if the resident's condition worsened or the family was not available via phone.

Eight and half hours later, ULP were concerned with the resident's continued and increasing pain and inability to transfer. ULP called the resident's family again and informed them of their concerns. The family member was upset they were not notified earlier of the resident's condition and told ULP they would come to the facility to check on the resident. The family arrived at the facility and after seeing the resident, called the ambulance to have the resident transported to the hospital for further evaluation.

Emergency department and hospital notes indicated the resident was taken to the emergency room due to left leg pain and could not stand or bear weight. Hospital records indicated the resident was normally able to ambulate independently with a walker. The resident's left lower extremity was visibly shorter when compared to the right and was externally rotated. The X-ray showed a left femoral neck fracture, and the resident was sent to another hospital for a higher level of care.

During an interview, the facility nurse stated she was the nurse on-call the day of the incident. She received a call from ULP indicating the resident was complaining of leg pain and was not able to walk or stand. The facility nurse instructed staff to call the resident's family member to see if they wanted her sent to the hospital. The nurse acknowledged that they did not call the facility back to follow up, did not contact the registered nurse (RN), did not instruct the unlicensed staff how they should care or monitor the resident, and did not contact a medical

doctor regarding the resident's acute change in condition. The nurse stated the resident should have been sent to the hospital sooner.

During investigative interviews, the ULPs that worked the day of the incident stated that morning before 8:00 a.m., the resident was not able to stand or bear weight and the resident would say, "my knee, my knee, I can't, I can't." The resident was more anxious and grabbed her knee during transfers. Staff called the on-call nurse, and they were instructed to monitor the resident and call the resident's family member. Around 9:00 a.m., a staff member attempted to contact the resident's family member and left a voicemail. Around 5:30 p.m., a staff member contacted the resident's family member again regarding the resident's condition. The staff stated the on-call nurse did not direct them on how to provide care for the resident and did not call back to follow up on the resident's change in condition.

During an interview, the registered nurse (RN) stated she was not notified of the incident until she returned to work two days later and noticed the resident was not at the facility. The RN stated the unlicensed staff should have called the secondary family contact listed in the resident's medical record if the first was not available. The RN stated she should have been contacted by the on-call nurse, an assessment should have been completed, and the doctor should have been contacted. The RN stated the resident's family member was very upset with the situation.

During an interview, the resident's family member stated the day prior the resident had many visitors and that entire day the resident was walking normally with a walker and did not complain of pain at that time. The family member stated she received a call around 5:30 p.m. indicating the resident's left leg had been hurting since that morning and she could not stand or bear weight on her left leg. When the family member arrived at the facility, the resident was sitting in a wheelchair slumped over and pale. The resident was taken to a local hospital and was found to have a hip fracture and sent to a higher level of care hospital for surgical intervention. Three days later, the family member went to the facility to find out what happened and why family was not contacted for more than eight hours after the resident began complaining of pain. The family member stated she was extremely angry due to the lack of care and that the nurse on-call did not ask enough questions, did not follow-up and blatantly failed with attempts to care for the resident. The family member stated, "there were so many failures along this chain of events, my mother had an emergency, and no one took it upon themselves to do what needed to be done."

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Jackson County Attorney
Heron Lake City Attorney
Heron Lake Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	C 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

(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 ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL305681407C/#HL305682342M On July 26, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 25residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for ##HL305681407C/#HL305682342M, tag identification 0620, 2310, 2360.	0 000		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of	0 620		

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0 620	Continued From page 1 maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	0 620		

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0 620	Continued From page 2 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults when a suspected incident of maltreatment was not reported to the Minnesota Adult Abuse Reporting Center (MARC) within twenty-four hours. The licensee failed to report an unexplained physical injury for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include:	0 620		

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0 620	Continued From page 3 R1's diagnoses included dementia, and insomnia. R1's face sheet included contact information for four family members. R1's undated, unsigned, service plan indicated R1 required morning and evening reminders, safety checks, toileting, and medication management. R1's assessment dated November 28, 2023, indicated R1 was independent with transfers and walked with a normal gait with a cane. The assessment indicated R1 did not use a wheelchair, was not at risk for falls and did not have pain. The assessment indicated R1 had severe cognitive impairment. R1's progress notes dated December 25, 2023, at 9:00 a.m., written on December 27, 2023, indicated staff assisted R1 with morning care and R1 complained of leg pain and was unable to stand or walk. The unlicensed personnel (ULP) contacted the on call nurse. The on call nurse instructed staff to monitor the resident and call family and see if they wanted R1 sent in. The ULP left a voicemail with R1's family member (FM). ULP gave R1 Tylenol and assisted her with toileting. R1' progress notes dated December 25, 2023, at 5:30 p.m., written on December 27, 2023, indicated R1 continued to have increased pain and required two assist with transfers. The ULP called R1's FM and the FM became upset that staff were just contacting her now. R1's FM told the ULP another FM would go and check on R1. R1's FM continued to inform staff she was not happy since it was now about 6:00 p.m. The ULP gave R1 more Tylenol and brought R1 out for	0 620		

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0 620	Continued From page 4 supper. R1's progress note dated December 25, 2023, at 7:20 p.m., written on December 29, 2023, indicated licensed practical nurse (LPN)-A received a call from the ULP and was informed R1 was sent to the emergency room due to pain. R1's progress notes dated December 27, 2023, indicated R1 had a hip fracture and was transferred to higher level of care. R1's emergency department and hospital notes dated December 25, 2023, at 7:47 p.m., indicated R1 presented to the ER since R1 did not want to stand up and bear weight on her left leg due to pain this morning and had to have assistance with transfers. The note indicated R1 was normally able to ambulate independently with a walker. R1's left lower extremity was shorter when compared to the right and was externally rotated. R1 had a history of falling and could potentially have fallen the night prior and got herself back up. The X-ray showed a left femoral neck fracture and R1 was sent to another hospital for a higher level of care. R1's medical record did not include an incident report or an internal investigation. On July 16, 2024, at 1:05 p.m., LPN/licensed assisted living director (LALD)-A stated she was the nurse on call December 25, 2023. LPN/LALD-A stated she received a call from ULP-D indicating R1 was complaining of leg pain and was not able to walk. She instructed ULP-D to call R1's FM to see if they wanted her sent in. LPN/LALD-A stated she did not call the facility back to follow up, did not contact the registered nurse (RN), did not instruct the unlicensed staff	0 620		

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0 620	Continued From page 5 how they should transfer R1, and did not contact a medical doctor regarding the change in condition. LPN/LALD-A stated this incident was not reported to Minnesota Adult Abuse Reporting Center (MAARC). On July 18, 2024, at 3:00 p.m., registered nurse (RN)-D stated she was not notified of the incident until she returned to work and noticed R1 was not at the facility. RN-D stated the ULP should have contacted another family member and the LPN/LALD should have contacted her, the doctor, and an assessment should have been completed. RN-D stated the LPN/LALD was her supervisor and she was not directed to report the incident to MAARC. The licensee's Report of Maltreatment of a Vulnerable Adult policy dated August 1, 2021, indicated team members who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident sustained a physical injury which is not reasonably explained will: a) Take immediate action to protect, or keep safe, the resident affection, b) call 911 if emergency assist is needed, c) contact the Clinical Nurse Supervisor if medical attention is needed, d) contact the assisted living director, e) The assisted living director or clinical nurse supervisor will determine how to best protect other residents form similar maltreatment in the immediate future, f) if suspicion of maltreatment, they will contact MAARC within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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02310	Continued From page 6	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when facility staff failed to assess a change in condition for one of one resident (R1) when staff informed the on-call nurse of R1's complaints of severe pain, change in transfer status, and inability to stand or bear weight on the left leg. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia, and insomnia. R1's face sheet included four emergency contacts including contact information. R1's undated, unsigned, service plan indicated R1 required morning and evening reminders for	02310		

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02310	Continued From page 7 dressing and grooming, safety checks, toileting, and medication management. R1's assessment dated November 28, 2023, indicated R1 was independent with transfers, walked with a normal gait with a cane. The assessment indicated R1 did not use a wheelchair, was not at risk for falls, and did not have pain. The assessment indicated R1 had severe cognitive impairment. R1's December, 2023, Medication Administration Record (MAR) indicated staff administered acetaminophen (Tylenol) on December 25, 2023, at 8:47 a.m. for pain in left leg/knee. At 9:47 a.m., a follow up note indicated Tylenol was not effective and R1 continued to have pain when attempting to stand. At 5:30 p.m., acetaminophen was again administered for left leg pain and was not effective. R1's progress notes dated December 25, 2023, at 9:00 a.m., written on December 27, 2023, indicated staff assisted R1 with a shower and R1 complained of leg pain and was unable to stand or walk. The unlicensed personnel (ULP) contacted the on call nurse. The on call nurse instructed staff to monitor the resident and call family and see if they wanted R1 sent in. The ULP left a voicemail with R1's family member (FM). ULP gave R1 Tylenol and assisted her with toileting. R1' progress notes dated December 25, 2023, at 5:30 p.m., written on December 27, 2023, indicated R1 continued to have increased pain and required 2 assist with transfers. The ULP called R1's FM and the FM became upset that staff were just contacting her now. R1's FM told the ULP another FM would go and check on R1.	02310		

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02310	Continued From page 8 R1's FM continued to inform staff she was not happy since it was now about 6:00 p.m. The ULP gave R1 more Tylenol and brought R1 out for supper. R1's progress note dated December 25, 2023, at 7:20 p.m., written on December 29, 2023, indicated the LPN received a call from the ULP and was informed R1 was sent to the emergency room due to pain. R1's progress notes dated December 27, 2023, indicated R1 had a hip fracture and was transferred to higher level of care. R1's emergency department and hospital notes dated December 25, 2023, at 7:47 p.m., indicated R1 presented to the ER since R1 did not want to stand up and bear weight on her left leg due to pain this morning and had to have assistance with transfers. The note indicated R1 was normally able to ambulate independently with a walker. R1's left lower extremity was shorter when compared to the right and was externally rotated. R1 had a history of falling and could potentially have fallen the night prior and got herself back up. The X-ray showed a left femoral neck fracture and R1 was sent to another hospital for a higher level of care. R1's medical record did not include an incident report or an internal investigation for December 25, 2023. On July 16, 2024, at 1:05 p.m., licensed practical nurse (LPN)/licensed assisted living director (LALD)-A stated she was the nurse on call December 25, 2023. LPN/LALD-A stated she received a call from ULP-D indicating R1 was complaining of leg pain and was not able to walk.	02310		

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02310	Continued From page 9 She instructed ULP-D to call R1's FM to see if they wanted her sent in. LPN/LALD-A stated she did not call the facility back to follow up, did not contact the registered nurse (RN), did not instruct the unlicensed staff how they should transfer R1, and did not contact a medical doctor regarding the change in condition. She stated she did not know how the ULP's cared for R1 during that time. She never contacted a RN when she was on call because she knew the residents and had worked with the company for nine years. LPN/LALD-A stated R1 should have been sent in sooner. LPN/LALD-A stated there was not an incident report or an internal investigation completed. On July 19, 2024, at 10:00 a.m., ULP-F stated she worked on December 25, 2023, before 8:00 a.m., R1 was not able to get up like usual so ULP-F assisted R1 to stand with a gait belt and had R1 sit on her walker and pushed R1 to the shower room. R1 could not stand so ULP-F contacted ULP-D for assistance. R1 continued to say, "my knee, my knee, I can't, I can't." ULP-F stated they looked at R1's skin and did not see any bruising. The staff continued to transfer R1 with two assist. On July 18, 2024, at 1:30 p.m., ULP-D stated R1 was normally able to walk and transfer independently. ULP-D stated on December 25, 2023, another ULP requested help transferring R1. R1 was not able to transfer and required 2 people to pivot transfer. ULP-D stated she called the on-call nurse and was directed to call R1's family to see if they want her sent in. ULP-D stated she left R1's family member (FM) a voicemail. ULP-D stated LPN/LALD did not give direction for how staff should care for R1. ULP-D administered R1 Tylenol. During the shift R1	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30568	A. BUILDING: _____ B. WING _____	C 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	941 10 STREET HERON LAKE, MN 56137

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02310	Continued From page 10 required two staff for transfers and a wheel chair. When they assisted R1 R1 kept saying, "I can't, I can't," was more anxious, grimacing, and would grab her knee and did not want to put weight on her left leg. ULP-D stated she was told to call the first person on R1's face sheet. Around 5:30 p.m., R1's FM had not called back so ULP-D again contacted R1's FM. ULP-D stated she did not call the LPN back and the LPN did not contact the facility to follow up on R1's condition. On July 18, 2024, at 3:00 p.m., registered nurse (RN)-D stated she was not notified of the incident until she returned to work and noticed R1 was not at the facility. RN-D was not on-call on December 25, 2023. RN-D stated the ULP should have contacted another family member and the LPN/LALD should have contacted herand an assessment should have been completed, and contacted the doctor. RN-D stated R1's FM was very upset with the situation. RN-D stated the LPN/LALD was her supervisor and she was not directed to report the incident to Minnesota Adult Abuse Reporting Center (MAARC). On July 16, 2024, at 2:00 p.m., FM-B stated she was R1's medical power of attorney. FM-B stated on December 24, 2023, R1's family was visiting and R1 was walking normally with a walker. FM-B stated R1 walked normally into the evening and did not complaint of pain during that time. FM-B stated she received a call on December 25, 2023, at 5:31 p.m., from ULP-D indicating R1's left leg was hurting since that morning and could not stand on her left leg. FM-B called other family to go and check on R1. When FM-B arrived R1 was sitting in a wheelchair slumped over and pale. FM-B stated the family contacted the ambulance. When three people assisted R1 to the ambulance cot, R1 winced in pain. R1 was taken to a local	02310		

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02310	Continued From page 11 hospital and was found to have a hip fracture so was sent to a higher level of care for surgical intervention. After the incident FM-B went to the facility to find out what happened and why no one was contacted for more than 8 hours after R1 began complaining of pain. FM-B stated there were many other people on R1's facesheet facility staff could have contacted. FM-B stated three days later she went to the facility and asked the registered nurse (RN) what happened, and the RN had not interviewed staff. FM-B stated she was extremely angry because R1 was neglected. FM-B stated the nurse on call did not ask enough questions, follow up and blatantly failed. FM-B stated, "there was so many failures along this chain of events when my mother (R1) had an emergency and no one took it upon themselves to do what needed to be done." The licensee's Residence Change in Condition or need dated August 1, 2021, indicated when a change in condition or need are identified a RN will initiate a change in condition assessment. The policy did not identify immediate interventions for a resident with an acute change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced	02360		

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02360	Continued From page 12 by: The facility failed to ensure one of one resident (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		