Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307359287M
Compliance #: HL307356941C

Date Concluded: March 15, 2024

Name, Address, and County of Licensee Investigated:
Walker Methodist Highview Hills
20150 Highview Ave
Lakeville, MN 55044
Dakota County

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

Evaluator's Name: Deb Schillinger 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 resident sustained a fracture of her pelvis with unknown origin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did sustain a broken pelvis, the facility took reasonable steps to prevent falls. The resident had several falls due to poor safety awareness related to dementia, and preferred to sleep on the floor, so at times slid herself off the bed to sleep on the floor.

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's record, facility policies and procedures, and incident reports. Also, the investigation included an onsite visit, observations of interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia and chronic pain. The resident's service plan included the resident needed the assistance of one caregiver for transferring, toileting, and medication management. The resident's assessment indicated physical assistance with ambulation with four-wheeled walker or wheelchair and was oriented only to self with poor safety awareness. The resident was enrolled in hospice.

The progress notes indicated one morning the resident complained of right hip and groin pain. The caregivers were able to reposition her on the bed and provided as needed pain medication. The same document indicated the facility updated both hospice and the resident's medical provider. X-ray results from the same day indicated the resident had a pelvic fracture. The resident remained at the facility and hospice made adjustments in her pain medications.

Facility incident reports and the resident's medical record indicated the resident was found on the floor several times over the 30 days prior to the resident being diagnosed with a fractured pelvis. Following each fall, the nursing staff completed an assessment for injuries with investigation and coordinated care with the hospice team. The same documents indicated there were times the resident fell and other times when she lowered herself to the floor due to her personal preference to be on the floor.

During an interview, the unlicensed caregiver reported the resident's pain on the day of the x-ray was different, the resident was in so much pain and was unable to tell staff where she hurt. The unlicensed caregiver stated the resident fell many times, but also slid herself from low bed to floor to sleep. The unlicensed caregiver stated the resident had scheduled checks every two hours.

During an interview, the family member stated the resident was used to sleeping on a mattress on the floor, had done this her entire life. When on hospice a low bed was provided, but the resident continued to put herself on the floor. The family member stated the resident was unable to use pendant. The family member stated during the interview she did not feel the resident fracturing her pelvis was due to neglect or abuse.

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, cognitively impaired.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility conducted an internal investigation and updated the resident’s service plan after coordinating care with the hospice team.

Action taken by the Minnesota Department of Health:
No 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
	30735	A. BUILDING: _____ B. WING _____	C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HIGHVIEW HILL	20150 HIGHVIEW 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 January 23, 2024 the Minnesota Department of Health initiated an investigation of complaints HL307358158C/HL307359951M, HL307357472C/HL307359646M and HL307356941C/HL307359287M. No correction orders are issued.	0 000		