Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307359646M
Compliance #: HL307357472C

Date Concluded: March 13, 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 abused the resident when the resident sustained bruising and skin tears of an unknown origin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the resident had bruising on her forearm with skin tears, the resident was on a long-term blood thinner medication, which caused an increased risk for bruising.

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 medical record. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included v dementia, anxiety, history of strokes, and atrial fibrillation, which required anticoagulant (medication that thins the blood). The resident's service plan included assistance with medication management, dressing, grooming, and safety checks. The resident's assessment indicated the resident was able to ambulate independently, took daily blood thinner, was cognitively impaired and at times needed redirection due to anxiety issues.

The facility incident report and internal investigation indicated the resident was found with two skin tears on her wrist. The documents indicated the unlicensed caregiver reported the resident was more agitated than usual, and the resident had pulled off her pendant breaking the metal piece that held the pendant to the lanyard. The resident was not able to recall how injury occurred and a nursed cleansed the area and applied a dressing. The facility notified the resident's medical provider and family.

The next day the same document indicated the resident developed bruising on the resident's same arm.

The resident's medical record indicated she received a prescribed blood thinner that increased her risk for bruising.

During an interview, unlicensed caregiver #1 stated the resident was agitated and "grumpy" when she first approached her to provide cares on the morning the skin tears were identified and that she noticed some bruising at that time. Caregiver #1 stated the resident told her to "get out" as she left the room to notify the nurse of the injury, who then assessed the resident.

During an interview, the nurse stated she assessed the resident's injury and dressed the skin tears but did not recall bruising. The nurse stated the resident was known to have fragile skin. The nurse stated she notified the family member and the provider after assisting the resident get dressed.

During an interview, unlicensed caregiver #2 stated the resident could be resistant to cares at times. Unlicensed caregiver #2 stated the resident talked to her about the injuries and initially said she did not how they happened but later identified one of the caregivers as causing the injury, but that caregiver was not working during the period the injuries occurred. The unlicensed caregiver #2 stated the resident is forgetful and has short term memory problems.

During an interview, unlicensed caregiver #3 stated she provided cares for the resident during the night shift prior to the injuries being discovered. She stated safety checks were completed last at 5 a.m. and remembered the resident was sleeping but did not recall the resident having any injuries.

During an interview, a family member stated she received a call from the nurse to notify her of injury and that the resident was "wound up. During a visit the next day, the family member

stated the resident said “someone did it to me” referring to the bruises, which were evident when the bandages were removed. The family member stated the resident’s skin is thin and fragile and that she is on blood thinners.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224.
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No, attempt not successful.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility investigated the incident and provided caregivers education.

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
	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		