Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307359951M
Compliance #: HL307358158C

Date Concluded: March 11, 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 resident #1 and resident #2 when resident #1 pushed resident #2 onto the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While resident #1 did push resident #2 onto the floor, the facility had provided resident #2's medical provider with updates and put interventions in place to address her behaviors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members of residents. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with residents, as well as resident to resident interactions.

Resident #1 resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia, anxiety, and a history of a traumatic brain injury. The resident's service plan indicated she had a history of physical and verbal altercations with staff members and other residents. Resident #1 walked independently but required frequent redirection.

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia and anxiety. The resident's service plan included assistance with cueing to complete cares. The assessment indicated she was independent with walking but required frequent redirection due to confusion.

A facility report indicated late one evening resident #1 and resident #2 were overheard arguing in a hallway so a caregiver headed towards them to intervene. Before the caregiver could reach them resident #2 bent over to pick up something from the floor and resident #1 pushed #2 who fell to the floor. Resident #2 complained of left hip pain and the facility arranged transport to the hospital

Resident #2's hospital report indicted resident #2 sustained a fracture of both the hip and wrist in the fall, requiring surgical repair of the hip.

Resident #1's medical record indicated the facility notified the resident's medical provider of the resident's agitation, who made changes made 10 days prior to the incident. The progress notes indicated the facility directed caregivers to redirect resident #1 along with PRN (as needed) medications, and items to carry as interventions to address resident #1's behaviors. Five days prior to the incident, the progress notes indicated these interventions were effective.

During an interview, an unlicensed caregiver stated that prior to the incident resident #2 was redirected back to her room several times from the dining room. During that same time, resident #1 was sitting in a different common area watching television. Eventually, resident #2 walked to where resident #1 was sitting and then the incident occurred.

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 investigated the incident and sent resident #2 to the hospital.

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		