Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308184481M
Compliance #: HL308185430C

Date Concluded: October 31, 2024

Name, Address, and County of Licensee Investigated:
Guardian Angels by the Lake
13439 185th Lane Northwest
Elk River, Minnesota 55330
Sherburne County

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

Evaluator's Name: Danyell Eccleston, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected Resident #1 and Resident #2 when the AP did not provide cares per Resident #1's and Resident #2's plan of care. In the morning hours, Resident #1 and Resident #2 were found on the floor in their separate apartments and taken to the hospital via emergency services.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to provide services to Resident #1 and Resident #2 according to their individual plan of care. Resident #1 was transferred to the hospital and diagnosed with rhabdomyolysis (a serious condition resulting from the death of muscle fibers releasing their contents into the blood stream after a traumatic event). Resident #2 was found with a cut to her left temple and dried blood on her face and diagnosed at the hospital with a subdural hemorrhage (a bleed under the membrane covering the brain). Video footage showed the AP sitting at the darkened nurses' station much of the night shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident records, death records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, video footage, and related facility policy and procedures. Also, the investigator observed staff members providing care to residents.

Resident #1 resided in an assisted living memory care unit. The resident's diagnoses included dementia, falls, and spinal cord disease. The resident's service plan included bed mobility with a physical assist of two staff at night and in the morning, transfers with a standing device and physical assist of two staff every two hours, toileting assistance or changing undergarments and peri care every two hours with assist of two staff, and safety checks. Resident #1's assessment indicated he had a history of falls, needed assistive equipment and two staff to walk or transfer, needed every two-hour continence care day and night, and had poor judgement, impulsivity, and confusion. The resident also had a history of self-transferring and falling without calling for assistance. Resident #1 frequently needed reassurance and redirection.

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included dementia, falls, and knee pain. The resident's service plan included pivot transfers with assistance of two staff, toileting assistance or changing undergarments and peri care every two hours with assist of two staff. The resident's assessment indicated the resident was talkative, but only some words were understandable, and she would not answer with appropriate words when asked questions. The Resident #2 had a history of falls, was incontinent of urine and bowel during the day and night, needed every two-hour assistance with continence cares, and required redirection.

Staffing records indicated during the night in question, the AP was the staff member stationed and specifically assigned to provide care on the memory care unit where Resident #1 and Resident #2 resided.

Review of video footage from the time in question indicated the AP spent most of the night shift sitting at the darkened nursing station. Video footage indicated staff members last entered Resident #1's apartment around 8:00 P.M. Video footage also indicated the AP did not enter Resident #1's apartment until approximately 5:00 A.M. when Resident #1 was found on the floor.

Resident #1 service documentation for the night in question indicated at 1:00 A.M., 3:00 A.M., and 5:00 A.M the AP documented he provided toileting with physical assist of two and transferring with standing device and physical assist of two. Further documentation indicated at 6:00 A.M. the AP provided bed mobility with physical assist of two, denture care, oral care, dressing assist, grooming, and stocking application.

Review of facility internal investigation documentation indicated at 5:00 A.M. the AP found Resident #1 on the floor when the AP walked by Resident #1's room. The investigation indicated Resident #1 had services due at 11:30 P.M., 1:00 A.M., 3:00 A.M., and 5:00 A.M. and all were signed off as completed by the AP. The AP indicated he and another staff member transferred the resident at 11:30 P.M. and entered Resident #1's room at 2:00 A.M. The internal investigation indicated a staff member stated she and the AP transferred Resident #1 between 7:00 P.M. and 8:00 P.M. The investigation indicated technology staff reviewed surveillance video footage and did not see staff enter Resident #1's apartment at 11:30 P.M. and that no staff member entered Resident #1's room on the night shift until the time he was found on the floor at approximately 5:00 A.M.

Review of incident report indicated Resident #1 was found on the floor in his living room complaining of right shoulder and arm pain. The lights and TV were on, and the resident's recliner was in a standing position. Emergency services was contacted.

Review of service documentation for Resident #2 the night in question indicated at 2:00 A.M. and 5:00 A.M. the AP documented he provided toileting with physical assist of two staff and transfer with physical assist of two staff. Further documentation indicated at 6:25 A.M. the AP provided bed mobility with physical assist of two staff, dressing, grooming, oral care, circulation stocking application, and assisted with the resident's visual aide.

Review of incident report indicated at 6:00 A.M. staff found Resident #2 on the floor laying on her left side with a swollen, cut and bleeding face. Resident #2 was unable to communicate events of the fall. Paramedics present for Resident #1 evaluated Resident #2 and an ambulance was called to take Resident #2 to the hospital.

Review of ambulance run report for Resident #2 indicated emergency services personnel noted Resident #2 had a cut to her left temple, bruising to the bridge of her nose, and dried blood around her nose and mouth. The report also indicated Resident #2 cried and ambulance crew consoled her.

Review of Resident #1's hospital records indicated Resident #1 admitted to the emergency department with rhabdomyolysis that was suspected to be related to him being down on the floor. Resident #1 was admitted to the hospital for further treatment and care.

Review of Resident #2's hospital records indicated the resident was found on the floor of her room and incontinent of urine with all her clothing wet. The resident also had a cut to her left temple and imaging results indicated the resident had a subdural hemorrhage near the left temple.

Review of the AP's record indicated he completed training about performing activities of daily living and providing care for residents with dementia. Approximately ten days prior to the night in question, the AP met with facility leaders due to concerns the AP was not providing cares as

scheduled. The AP was re-educated that all scheduled services should be completed and if a resident declined night shift services or wished not the be woken, the AP needed to discuss the matter with a nurse.

During separate interviews, three leadership members stated they reviewed video footage from the night shift in question and did not see the AP go into Resident #1's room until he was found on the floor. The interviews indicated the AP stayed at the nurses' desk most of the night shift.

During separate interviews, unlicensed staff members present at the facility during the time in question stated the AP did not call for assistance to bathroom or transfer any resident during the night.

During separate interviews, four unlicensed staff members stated the AP would sleep at the nurses' station during shifts.

During interview, an unlicensed staff member indicated she worked the night in question and was assigned to float to floors to assist staff with residents. The unlicensed staff member indicated she was not called during the night shift by the AP to assist with services for Resident #1 and Resident #2. The staff member stated she heard the AP's morning call for assistance and went to Resident #1's apartment. The staff member saw Resident #1 lying on the floor and heard him report severe pain in his arm. The unlicensed staff member contacted the on-call nurse and waited for the paramedics to arrive. After the paramedics arrived, the AP informed the unlicensed staff member that Resident #2 was on the floor. When the unlicensed staff member arrived in Resident #2's apartment, the staff member saw Resident #2 lying on the floor next to her bed with a cut and dried blood on her face. Due to Resident #2's cognitive state, she was not able to communicate what happened or how long she was lying on the floor. A second paramedic crew arrived and took Resident #2 to the hospital. The unlicensed staff member stated she assisted in completing incident reports for the resident's and the AP told her he last toileted Resident #1 at 11:30 P.M. and Resident #2 at 3:00 A.M.

During interview, the AP stated it was not appropriate to falsely document completing cares and he did not know why video footage showed him sitting at the nursing desk most of the shift in question. The AP stated both Resident #1 and Resident #2 were incontinent, and he checked to see if they were wet. Despite previously stating Resident #1 was usually wet with urine, AP stated he did not need to enter Resident #1's apartment because he could see Resident #1 sleeping in a chair from the main hallway and could tell from the main hallway that Resident #1 was not wet with urine, soiled with feces, or needed to be toileted. When asked about completed documentation regarding grooming, dressing, applying compression stockings, and providing oral care to Resident #1 and Resident #2 after the time they were each found on the floor, the AP stated he must have made a mistake.

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, Resident #1 and Resident #2 deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The alleged perpetrator is no longer employed by the facility. The facility obtained additional video cameras and implemented an audit process to assist in ensuring residents receive cares.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
Elk River City Attorney
Elk River Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL308185430C/#HL308184481M On August 27, 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 89 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL308185430C/#HL308184481M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		