Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318762060M
Compliance #: HL318769965C

Date Concluded: August 6, 2024

Name, Address, and County of Licensee Investigated:
Elysian Senior Homes of Lake City
480 West Grant Street
Lake City, MN 55041
Goodhue County

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

Evaluator's Name: Deb Schillinger 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 resident #1 and resident #2 when the facility did not provide sufficient supervision and the two residents engaged in possible sexual activity.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. While the relationship between resident #1 and resident #2 may have been consensual, the facility staff did not assess, document, or implement a plan of care to ensure the residents were free from abuse within the relationship.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted decision makers of both residents. The investigation included review of the resident records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

Both resident #1 and resident #2 resided on the same assisted living memory care unit. During the time that both residents lived there a concern arose that resident #2 would go to resident #1's room and the two would get undressed together.

Resident #1
Resident #1's diagnoses included Alzheimer's disease, dementia, and anxiety. Resident #1's service plan included assistance with medication management, cueing and safety checks. The resident assessment indicated resident #1 had memory impairment, but was able to make oneself understood, and could walk independently.

Resident #1's assessment indicated areas of potential vulnerability and interventions designed to address the area of vulnerability would be described in the resident's care plan. However, resident #1's care plan mirrored the same documentation regarding the safety vulnerability; "Interventions designed to address area of vulnerability are described on the residents care plan".

A review of resident #1's medical record failed to identify interventions addressing the areas of vulnerability identified in neither the RN assessment, care plan nor in the individual abuse prevention plan (IAPP).

Resident #2
Resident #2's diagnoses included dementia, mood disturbance and anxiety. Resident #2's service plan included assistance with medication management, cueing and safety checks. The resident's assessment indicated the resident had memory impairment and poor judgement, was unable to identify an unsafe situation(s) and was able to walk independently.

A review of resident #2's medical record did not identify an assessment addressing resident #2's view of relationship with resident #1. The same document included no instructions or interventions for unlicensed caregivers to provide supervision or monitoring of resident #2 to ensure her safety.

Interviews
During an interview, a member of administration indicated a relationship formed after resident #1 admitted into the memory care unit. She indicated both resident #1 and resident #2 would seek each other out and would become upset if staff tried to separate them. The member of administration stated the facility engaged in discussions with both resident #1 and resident #2's decision-makers.

A review of the resident #1 and resident #2's medical record did not identify documentation of the communication described by the member of administration.

During an interview, an unlicensed caregiver reported she attempted to keep resident #1 and resident #2 out of each other's rooms, however, the demands of providing care to the other residents as well made this difficult. The unlicensed caregiver stated she was unsure whether anyone from the facility had interviewed either resident to determine if they both wanted to be with each other. She stated she believed they did want to be together because they sought each other out. During the same interview, the unlicensed caregiver stated caregivers would know how to provide care for each resident by reviewing each resident's care plan.

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, both R1 and R2 cognitively impaired
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Resident #1 moved to new facility prior to the investigation.

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
Goodhue County Attorney
Lake City, MN City Attorney
Lake City, MN Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE CITY	480 WEST GRANT STREET LAKE CITY, MN 55041

(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: #HL318769965C/#HL318762060M On July 03, 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 61 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL318769965C/#HL318762060M, tag identification 0630 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to update individual abuse prevention plans (IAPP)s and develop individualized interventions to ensure safety and prevent harm to two of two (R1 and R2) residents reviewed after the residents were reportedly involved in a known ongoing intimate relationship. 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). The findings include: During an inteview July 8, 2024, R1's power-of-attorney (POA) stated R1 and R2 spent time together and at times undressed. POA stated she discussed this with the facility administration and caregivers on multiple	0 630		

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0 630	Continued From page 2 occassions in late 2023 and early 2024. R1 R1 was admitted to the memory care unit on October 28, 2023, with diagnoses including Alzheimer's disease, dementia, and anxiety. R1's care plan dated February 1, 2024, indicated R1 required assistance with medication management, cueing and safety checks. R1's comprehensive assessment dated February 1, 2024, indicated R1 was not at risk to abuse others and had areas of identified vulnerability. The same document indicated interventions to address the area of vulnerability could be found described in R1's care plan. R1's care plan dated February 1, 2024, indicated R1 had areas of vulnerability and those interventions could be found in R1's comprehesnive assessment. A review of both documents found neither included a descrption of R1's vulnerability nor interventions. R1's IAPP dated on March 1, 2024, mirrored the same statements found on the comprehensive assessment and care plan indicating R1 was not at risk to abuse others and had areas of identified vulnerability and interventions to address the area of vulnerability are described in R1's care plan. R2 R2 was admitted to the memory care unit on May 19, 2023, with diagnoses including dementia, mood disturbance and anxiety.	0 630		

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0 630	Continued From page 3 R2's master care plan dated February 6, 2024, included assistance with medication management, cueing and safety checks. R2's care plan indicated cognitive impairment and R2 is unable to identify an unsafe situation. R2's comprehensive assessment dated February 6, 2024, indicated resident was sometimes able to make self understood, demonstrated poor judgement, was unable to identify an unsafe situation and demonstrated occasional agitation. A review of R2's medical record did not identify doucmentation addressing a relationship with R1, indicate an assessment addressing R2's view of relationship with R1, or include instructions or interventions for unlicensed caregivers to provide supervision or monitoring of R2 to ensure her safety. A review of the medical record did not reveal documentation of assessments to understand if both residents were consenting to the relationship, interventions to guide unlicensed caregivers on how to care for R1 and R2 or ongoing monitoring to assess status of relationship. During an interview on July 3, 2024, with a member of administration, R1 and R2 formed a relationship while residing in the facility's memory care unit. She also stated both R1 and R2's decision makers were notified of the situation. During an interview on July 10, 2024, the nurse stated she was unsure if R1 or R2 were assessed for consent or if their respective care plans were updated.	0 630		

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0 630	Continued From page 4 The licensee's Individual Abuse Prevention Plan policy, dated August 01, 2021, indicated the facility would develop and implement an individualized abuse prevention plan for each vulnerable adult. The plan also indicated the IAPP "will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults". TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 by: The facility failed to ensure two of two resident(s) reviewed (R1 and R2) were free from maltreatment. The 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	Please see public maltreatment report for details.	