Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319871842M
Compliance #: HL319873172C

Date Concluded: May 27, 2025

Name, Address, and County of Licensee Investigated:
Northern Lakes Senior Living
8186 Excelsior Road
Baxter, MN 56425
Crow Wing County

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

Evaluator's Name: Katherine Barnhardt, 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 the resident when licensed staff refused to contact emergency services for transportation for the resident when the resident complained of being ill and wanted to be evaluated at a hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility licensed staff refused to arrange for the resident to be evaluated at a hospital when the resident complained of illness and requested emergency transport to a hospital. The resident waited over four hours until family could be reached and arrange for the resident's emergency transport to a hospital for an evaluation. The resident was hospitalized four days for severe dehydration, Norovirus (illness with symptoms of nausea, vomiting, diarrhea, and stomach pain) and Covid-19. In addition, licensed staff determined the resident's illness was not emergent without obtaining the resident's vital signs or completing a change of condition assessment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted medical facilities and a family member. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff provide direct cares.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes and high blood pressure. The resident's service plan included assistance with safety checks twice daily, laundry and housekeeping. The resident's assessment indicated facility staff prepared the resident three meals daily. The resident managed his own medications, managed his own finances and was orientated to person, place, time and situation. The resident was independent with most activities of daily living, walked independently with a four-wheel walker and participated in physical therapy weekly.

The resident's record indicated the resident purchased a minimum service package from the facility. The package included laundry, housekeeping and safety checks twice daily. The resident, when not ill, arranged his own transportation, managed his own medications and was able to communicate his needs. The resident was scheduled for staff to check the resident's vital signs the day the resident complained about not feeling well, however, the documentation was signed off as refused by unlicensed personnel and stated, "could not get today due to having Noro" (Norovirus). The resident independently utilized a call pendant when staff assistance was needed.

Call pendant records indicated the resident typically requested staff assistance with a call pendant one to two times daily, however, the morning of the hospital transport request, the resident utilized his call pendant for staff assistance seven times between 3:25 a.m. and 10:28 a.m.

Progress notes indicated one morning, unlicensed personnel notified a licensed staff of the resident's change in condition after the resident used a call pendant for assistance. The resident reported vomiting and diarrhea and requested to go to a hospital at 9:12 a.m. The unlicensed personnel requested assistance from the licensed staff that morning and documented the resident required two staff to assist with toileting, transferring and ambulation. Nursing leadership directed the licensed staff to have the resident call family or 911 for transportation. The licensed staff observed the resident phone family, but family was unavailable and did not answer the phone call. Licensed and unlicensed personnel assisted the resident back to bed and attempted to reach the resident's family, however, did not call for a hospital transport as requested by the resident. Licensed staff spoke to the resident's family a few hours later by phone and were told by the family they were unable to transport the resident themselves and requested the facility call 911 for the resident. Instead, licensed staff provided the family member with a non-emergent phone number for transport and directed the family to call

because licensed staff had not assessed the resident's illness to be emergent. The family arranged for the resident to be transported to a hospital at 1:32 p.m., four and a half hours after the resident requested facility staff to send him to the hospital.

Hospital records indicated the resident arrived at the emergency department at 1:58 p.m. by ambulance. The resident reported he was unsure of when the symptoms of the illness began, a day or two earlier. The resident reported to the hospital provider he was unable to get around that morning due to weakness and fatigue. The hospital provider noted the resident was pale, somewhat ill-appearing, had a temperature of 100.4 Fahrenheit and became hypotensive (blood flow through the arteries becomes too low) in the emergency room. The resident's cognitive status was baseline and alert. The provider ordered an intravenous infusion of fluids for dehydration and tests indicated the resident was positive for Covid-19 and Norovirus. The resident required hospitalization for four days due to significant difficulty caring for himself and dehydration.

Facility internal investigation documents indicated the facility did not initiate an internal investigation until three days after the incident. The internal investigation conducted by facility management indicated the resident had been trying to reach family unsuccessfully and requested facility staff send him to the hospital. The internal investigation indicated when the family was reached several hours after the resident's initial transport request, a family member requested the facility staff call 911. The family was told the facility did not consider the resident illness emergent and the family was directed to call 911 if they chose. The internal investigation indicated family called 911 for a hospital transport for the resident. The facility's internal finding indicated facility staff should have called 911 rather than "making the request of family to do so".

During an interview, nursing leadership stated the facility's 911 policy did not directly provide guidance when a resident asked to be sent to a hospital if the resident was not receiving nursing services. Nursing leadership stated the facility had a list of items within a 911 policy that they used as guidance to determine what was considered an emergency and in combination with an assessment of the resident. Nursing leadership stated she thought vital signs were taken the morning of the resident's report of illness and recalled a licensed staff providing the information, however, no vital signs were documented. Nursing leadership stated the resident's service package was taken into consideration when staff decided the resident should arrange his own transportation or if facility staff should assist with transport arrangements. Nursing leadership stated the resident did not receive nursing services and had arranged his own transportation in the past and the decision was made to contact family for transportation arrangements to support the resident's choice to be seen by a medical provider. Nursing leadership stated both herself and the licensed staff had a background in critical care and determined the resident's illness was not an emergency. Nursing leadership stated the resident's symptoms were like his previous Covid-19 illness and a licensed staff had completed an assessment "in her head". Nursing leadership stated if the event was emergent and family were unable to be reached in a timely manner, 30 – 45 minutes, the facility would request

emergency transport. Nursing leadership stated the family called 911 when reached by phone several hours later.

During an interview, licensed staff stated she and an unlicensed personnel had assisted the resident with cares and a two-person transfer the morning the resident requested transportation to the hospital. Licensed staff stated she did not feel the illness was an emergency, however, supported the resident's request to be seen by a medical provider. Licensed staff stated while she was in the room the resident did make a phone call to family; however, the call went unanswered. Licensed staff stated missed phone calls between herself, and the resident's family went back and forth over a period of hours before licensed staff spoke with a family member. Licensed staff stated because the resident did not receive nursing services, attempts were made to contact the family to arrange the resident's transportation to a hospital. Otherwise, the resident could make his own arrangements by contacting 911. The licensed staff stated the facility did not feel the resident's illness was an emergency however, the facility failed to provide the investigator with the resident's assessment and vital signs.

During an interview, the resident stated he had gone to the hospital and could not recall the events of the morning because he was very sick, too weak to get out of bed and felt he could have died. The resident stated he had requested transport to the hospital and could not understand why licensed staff delayed a hospital transport when he had requested it.

During interview, a family member stated the resident had been independent with most activities of daily living prior to the morning he requested facility staff send him to a hospital. A family member stated the resident had attempted to face time call her while she was at work, but she had been unable to take the call. A family member stated sometime later while still at work she checked her phone and had a missed call from licensed staff at the facility. The family member made several unsuccessful attempts to reach licensed staff at the facility over the next few hours. The family member stated she made attempts to speak with the resident during the same period and when the resident was reached it was difficult to understand him because he was talking very low due saying he was weak and ill. The family member stated when she reached licensed staff four and a half hours later the licensed staff stated nursing leadership had directed the family or the resident to call 911 due to the resident's service package. The family member called 911 and the resident was transported to the emergency room where he was treated for severe dehydration and weakness due to Covid-19 and Norovirus for four days.

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

Action taken by facility:
Unlicensed facility staff assisted the resident during his illness and notified licensed staff of the request for a hospital transport.

Action taken by the Minnesota Department of Health:
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

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
Crow Wing County Attorney
Baxter City Attorney
Baxter Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31987	A. BUILDING: _____ B. WING _____	C 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LAKES SENIOR LIVING	8186 EXCELSIOR ROAD BAXTER, MN 56425

(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: #HL319873172C/#HL319871842M On May 9, 2025, 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 65 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL319873172C/#HL319871842M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

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02360	Continued From page 1	02360		
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 one of one resident reviewed (R1) was free from maltreatment. 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		