Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319879288M
Compliance #: HL319877042C

Date Concluded: March 5, 2024

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

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

Evaluator's Name: Lena Gangestad, 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 the resident when the facility did not provide updated services resulting in multiple falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did fall multiple times during the last two months of his life, the facility did put interventions in place to prevent falls and/or injury. While the resident did have a decline, he was enrolled in hospice and the facility coordinated cares with hospice appropriately.

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 ombudsman and hospice nurse. The investigation included review of resident's records, incident reports, and the resident's external medical record.

The resident resided in a secured memory care building within an assisted living facility. The resident's diagnoses included dementia and Parkinson's disease. The service plan indicated he required assistance of one person for walking, personal hygiene, dressing, and toileting. The caregivers were to remind the resident to use the bathroom and/or change his clothes and provide incontinence cares as needed. Additionally, the service plan included nightly safety checks, with instructions from the family not to wake the resident up during the night. Caregivers provided redirection for the resident if he wandered.

The resident's medical record indicated he initially moved into the facility to reside in an assisted living apartment. After several years, as his dementia progressed, the family opted to transition him into memory care. During his seven months in memory care, his health deteriorated rapidly. During the last two months of his life, the resident had multiple falls with no reported injuries. The same documents indicated his behaviors became challenging for caregivers as he became resistive to cares with aggressive behaviors. The resident admitted to hospice and passed away two months later.

During an interview, a family member stated the family shared their concerns about the care the resident received with the facility. The family had a camera in the resident's room and observed caregivers did not check on the resident as frequently as expected. Instead, they just opened the door, glanced inside, and left. The family had to contact the facility multiple times to report when they observed the fall over the camera, which occurred seventeen times in the last two months of his life. The family member said after they voiced their concerns, caregivers would move the resident out of the room early in the morning and keep him in a wheelchair near the nursing station for the entire day, where the family could not monitor him via the camera. The family member stated they were concerned the facility did not provide adequate hydration or provide the services as outlined in the care plan. The family member stated the facility tried to raise the resident's charges by raising his level of care from "four" to "eleven" [based on the facility's rating system] without justification. At times, as many as five caregivers entered the resident's room but only two of the five were actively assisting the resident with incontinence cares. The family member stated a concerning incident occurred when a caregiver held the resident's arm down, which the family perceived as abusive. The family member stated the caregivers overmedicated the resident by excessive use of "as-needed" medications. The family member stated that on one occasion, the resident made a train-like noise loudly in his room for over half an hour, but no caregivers responded. The family member stated they reported the situation to adult protection services, who investigated and found no concerns regarding the care.

During an interview, manager #1 stated the resident initially resided in assisted living but was moved to the memory care unit as his condition worsened. She said he became increasingly aggressive towards staff and required frequent redirection. At times, he would yell and scream in his room, prompting caregivers to accompany him to ensure his safety. The caregivers documented the cares the resident required, and this information was shared with the resident's family however, the family expressed disbelief regarding the drastic changes in the

resident's cares. Manager #1 stated this led to accusations towards staff members, which resulted in the facility filing a restraining order against one of the family members. Management staff #1 stated the facility informed the resident's cares had increased from a level "four" to an "eleven" but the family insisted the resident required level "five" only. Manager #1 stated the family refused to sign the new service plan for level "eleven". Manager #1 stated the resident's cares generally required two caregivers, however because of the resident's aggressiveness during cares often three to five caregivers present in the room, which was to help him calm down so the direct caregivers could do so effectively.

During an interview, manager #2 said the resident did fall numerous times during the last two months of his life despite the implementation of various interventions to prevent them, such as shoes, grip socks, fall mats, and a Broda chair [a specialized chair for positioning and fall prevention]. At times, the caregivers kept the resident close to the nurse's station for added supervision and safety. Manager #2 stated the resident was highly confused and restless, often attempting to get up by himself or lean over in his wheelchair. Despite staffing constraints, the facility conducted hours safety checks on the resident. Manager #2 stated the resident often became agitated at night and caregivers kept him at the nursing station for supervision. Manager #2 stated the family expressed dissatisfaction with the resident being placed in a chair at the nurse's station at night and apparently view it as insufficient care. Manager #2 said the family requested one-on-one care, but the facility explained it could not provide this. Manager #2 stated that while the resident had "as-needed" medications for pain, but the family wanted the caregivers to seek approval from the family or hospice before each administration. Regarding care levels, manager #2 stated level 5 applied to someone who required stand-by assistance, but the resident required two-person physical assistance with a Hoyer lift, but the family would not agree to a higher level of care. Management staff #2 stated there were ongoing discussions with the family about the potential transition to a nursing home due to the facility's inability to provide one-on-one care. The family indicated they were exploring other options, although there no formal requests for transfer.

During the same interview, manager #2 addressed an incident capture on the family's camera. Manager #2 stated the family claimed a caregiver was restraining the resident, but further investigation led to conflicting interpretations. The video footage was reviewed by others, including a social worker, a resident advocate, and multiple members of the facility management who did not share the view it was evidence of abuse. Manager #2 stated caregivers did express that providing cares for the resident was made more difficult due to the limitations use of "as needed" medications especially when the resident exhibited agitation and aggression through behaviors like hitting, swinging and pulling at his caregivers.

During an interview, a resident advocate familiar with the resident's cares stated she had reviewed video footage provided by the family. The concerns included occasions when multiple caregivers entered the resident's room which might have been intimidating to the resident. The advocate stated the facility's explanation for the presence of multiple caregivers was due to safety concerns and the resident's potential aggressive behavior. The advocate stated the

family said they were concerned because the facility would keep the resident outside of the room most of the day and family could not watch him via camera. The advocate did visit the resident but did not witness any aggressive behavior. The advocate stated she did ask caregivers how the resident transferred, and the responses varied with some saying he required a Hoyer lift and two-person assistance while others said one-person physical assistance, but this seemed to vary based on the physical strength of the caregiver. The advocate stated she also viewed video footage provided by the family in which the family felt a caregiver mistreated the resident. The advocate stated the footage showed two caregivers trying to provide incontinence cares while he was in bed. The resident was moving around while they changed him and one of the caregiver's hands was placed on the resident's arm however she could not tell whether her hand was resting there, or she was holding him down or grabbing him. The advocate could not tell whether the resident was yelling out or not.

During an interview, a hospice nurse said she was part of the care team for the resident during the last two months prior to his passing. The hospice nurse stated the resident's health declined rapidly during this time. She stated she felt the care provided by the facility was adequate although the resident often refused cares and the resident's rapid decline was stressful for the family. The hospice nurse stated the resident exhibited numerous behavioral issues and use of "as needed" medications were appropriate. Despite trying various interventions, the resident's behavior persisted, with instances of aggression towards caregivers, although to her knowledge he never hurt any of them. The nurse described the resident's nighttime behavior as reminiscent of someone experiencing flashbacks from war and manifested signs of post-traumatic stress disorder (PTSD) along with heightened anxiety and agitation. The hospice nurse stated that facility caregivers typically do not need to consult with hospice before administration of each "as needed" medication, but in this instance, the facility caregivers did so.

During an interview, staff member #1 said the resident had behavior issues toward the end of his life and sometimes it required the assistance of three to four staff members to calm him down. She stated his level of care fluctuated from day to day depending on his strength, ranging from needing one-person assistance to requiring a hoyer lift with two persons. On his better days, he could participate in his care, but on worse days, he was unable to do anything at all. Staff member #1 stated caregivers often brought the resident into the dining room to keep a closer watch on him as it was challenging to supervise him while he was in his room. She stated the resident was placed on two-hour checks, but this was eventually increased to hourly checks. Regarding medication administration, caregivers needed to contact triage for approval before administering any as-needed medication and triage, in turn, contacted the family or hospice for approval.

During an interview, staff member #2 said in the past the resident required assistance of one person for his cares and he was cooperative. However, as time went on, the resident's condition deteriorated, requiring care from two people due to both physical decline and behavioral challenges, including resistance to care. Staff member #2 stated she observed his behaviors

worsen after the discontinuation of some of his medications, which led to “rough” period in which he refused any touch for cares, and he often spoke of his experiences of war.
She said staff attempted various techniques to redirect and distract him, including offering snacks and engaging him in different activities, but found it challenging due to his resistance. There were instances where four to five staff members were needed in the room to assist with changing his incontinence brief, as he resisted care. Staff member #2 stated most of his falls were due to behavioral issues such as attempting to walk on his own despite lacking the strength to do so. To mitigate some these risks the facility provided him with a different [Broda] chair and placed a fall mat next to his bed whenever he was resting in it. Throughout the day, the caregivers tried to keep him closely monitored his condition, adhere to his toileting schedule, and administering medication as needed along with checks.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	31987	A. BUILDING: _____ B. WING _____	C 01/30/2024

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 On January 30, 2024, the Minnesota Department of Health initiated an investigation of complaints HL319879288M/HL319877042C. No correction orders are issued.	0 000		