Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL335249902M
Compliance #: HL335249841C

Date Concluded: May 7, 2025

Name, Address, and County of Licensee Investigated:
The Moments of Lakeville
16258 Kenyon Avenue
Lakeville, MN 55044
Dakota County

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

Evaluator's Name: Danyell Eccleston, 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 the facility failed to ensure the kitchen door was secured when no staff were present during non-mealtime hours. The resident was noted as missing and later found in a walk-in cooler and freezer inside of the kitchen. The resident went to the hospital where she was treated for hypothermia (a condition when the core body temperature drops below 95 degrees, created by factors that cause the body to be unable to regulate temperature).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility kitchen door was not secured and the resident was able to access the kitchen which contained a walk-in cooler and freezer unnoticed. The resident entered the walk-in cooler and freezer and was able to lock the door from the inside when the cooler was set to 37 degrees. Emergency medical response was summoned and the resident went to the hospital for treatment.

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 the resident's medical records, facility internal investigation, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff members providing care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and her service plan included every two-hour safety checks and assistance to make safe decisions. The resident's assessment indicated the resident had impaired memory and orientation and needed assistance making appropriate decisions about her care and environment. The resident's assessment also indicated she had difficulty communicating and receiving information.

Physical observation indicated the kitchen had a main door with a locking knob followed by a pair of swinging doors. Observation inside the kitchen revealed an unsecured door that opened to a walk-in cooler. At the back of the cooler, another unsecured door led to the walk-in freezer.

Review of facility video footage indicated on the afternoon in question, the resident walked around the dining area, opened the main door to the kitchen, walked through the additional swinging French doors and then was no longer visible. Approximately two minutes later, a man is seen entering the kitchen and then closing all kitchen doors upon exit. Approximately two and a half hours later, video footage showed the resident walking out of the kitchen area with assistance of staff members.

Review of facility incident report indicated staff noted the resident was not present at dinner and then staff searched the resident's room, unlocked rooms, and the connecting building. The resident's family members and the police were contacted. Staff members continued to search for the resident, including the facility grounds and neighboring businesses. A staff member noted the walk-in cooler and freezer door was locked, which was unusual, and knocked on the door and someone knocked back. Staff members located the walk-in cooler freezer key, unlocked the door, and found the resident inside, cold and shaking. Emergency services was contacted and staff assisted the resident to sit and wrapped the resident in a blanket.

Review of law enforcement report indicated police were dispatched to the facility due to a missing person report. Police spoke with a facility nurse about the actions the facility took to find the resident. A kitchen staff member informed the nurse that they thought they heard knocking from the walk-in cooler door. The nurse took the police to the kitchen and showed the police the walk-in cooler and freezer door, but it was locked. Upon unlocking the first door, no one was seen, however, police unlocked a second door that led to the freezer and found the resident inside. Medics arrived at the facility and the resident's internal temperature was 92.6 degrees. Medics transported the resident to the hospital.

Review of hospital records indicated upon arrival the resident was covered in blankets and cold to the touch. The resident could not state how long she had been in the walk-in cooler and freezer, but reported she felt cold. The resident received warmed intravenous fluids and a heating device was applied to raise the resident's temperature. Later that evening, the resident was discharged back to the facility.

During interview, a nurse stated the resident was very mobile and liked to walk around the community. The resident was curious and enjoyed looking at things and arranging items, such as flowers, vases, and pillows. It was not uncommon for the resident to walk into other apartments and rooms to explore.

During interview, an unlicensed personnel member stated she saw the resident in her apartment at the beginning of shift and around dinner time, approximately two hours later, the resident was unable to be found. The unlicensed staff member notified other staff and multiple staff began searching for the resident, police were also contacted.

During interview, a second nurse stated she was in her office when informed the resident was not at dinner. All facility floors were made aware the resident was missing and a search of the entire building, attached building, and grounds to find the resident began. Emergency services was contacted. The second nurse stated a staff member called and stated they thought the resident was in the walk-in cooler and freezer, which was atypically locked. Staff searched for and found the walk-in cooler key. When the walk-in was unlocked, the resident was found inside, shaking and blue. A request was made for emergency medical services and the resident went to the hospital and was treated for hypothermia.

During interview, a leadership member stated during the time of the incident, the kitchen door was to be locked and it was unknown if the kitchen door was left unlocked during the time of the incident or if there was a mechanical issue with the door. After the incident, maintenance was completed to the kitchen door and mechanisms that allow the walk-in cooler doors to be locked were removed.

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:
Facility conducted internal review of incident, communication to staff, removal of walk-in cooler locks, maintenance of kitchen door and lock.

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
Dakota County Attorney
Lakeville City Attorney
Lakeville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON 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 ******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: #HL335249841C/#HL335249902M On April 1, 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 86 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL335249841C/#HL335249902M, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON 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
02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) 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	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.	