

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366513042M
Compliance #: HL366514956C

Date Concluded: August 28, 2023

Name, Address, and County of Licensee

Investigated:

Lexington Pointe Senior Living
3385 Discovery Road
Eagan, MN, 55121
Dakota County

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

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide adequate incontinence care and as a result the resident developed a groin rash. In addition, the facility failed to provide interventions to prevent the resident from falling.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility staff provided toileting, incontinence care, and services according to the resident's service plan. While the resident did develop a groin rash, a protective cream was ordered, and staff provided the treatment. Two weeks later, the rash improved. The resident was experiencing a decline in health and was on hospice services. The facility nurse assessed the resident after each fall, put interventions in place to decrease the risks of falls, and updated the resident's hospice and medical providers.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of resident's record, assessments, service delivery records, incident reports, hospice records, and policies and procedures. The investigator toured the facility, the resident's memory care unit, and observed staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with toileting, incontinence cares, and one to two staff assist for transfers, used a walker to ambulate, and had hourly safety checks. The resident's assessment indicated the resident was incontinent of bowel and bladder. The same assessment indicated the resident had a history of falls. The resident received hospice services.

The resident's services delivered record indicated facility staff provided the resident toileting and incontinence care services twelve times a day.

The residents progress notes indicated the resident developed a groin rash. The facility received orders to apply Z Guard cream (cream to treat and prevent skin irritation) to the resident's groin twice daily and as needed until rash resolved.

The resident's medication administration record indicated the resident had a cream treatment scheduled and indicated staff applied the cream.

The resident's hospice records indicated the resident had groin dermatitis (skin irritation that causes dry itchy skin.) Two weeks later, the rash had improved. Four days after that, records indicated there was "barely any rash left in the groin area."

The resident's incident report indicated during an overnight shift staff found the resident on his apartment floor without injury. Following an assessment, the facility added a bed sensor (alarm to alert when attempting to leave bed) and hourly safety checks to the resident's services as fall prevention interventions.

The resident's services delivered record indicated staff provided the resident hourly safety checks.

Six weeks later, when ambulating in his room using his walker, the resident said he was tired and sat on the floor without injury. Following an assessment, the facility added a mechanical lift for all transfers as a fall prevention intervention. After both falls, the facility nurse updated the resident's hospice and medical providers.

During an interview, a nurse stated staff provided the resident with toileting and incontinence care. The resident developed a rash, and Z-guard was ordered and applied by staff. A nurse stated the resident was experiencing a decline in health and was on hospice services. The nurse

stated after the resident fell, a nurse assessed the resident and interventions were added to the service plan.

Additional concerns were identified in the complaint. There was a concern the resident was not receiving his oral medications. The resident's medication administration record indicated the resident received medications as ordered.

There was a concern with lack of staffing and availability of a nurse on call. Review of the staff schedule indicated the facility consistently staffed the resident's memory care unit according to their staffing plan. During an onsite visit, staff members were observed working on the unit as indicated on the schedule. The facility also had licensed nursing staff scheduled and a nurse on call 24/7.

Another concern was a resident on the unit went into other resident rooms and appeared threatening. Review of facility records did not identify a resident who went into other resident rooms and threatened them. A nurse stated the memory care unit did have a couple of residents who wandered but had not received reports from staff of concerns for a resident's safety.

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: No. Attempted but did not reach.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility staff provided services according to the resident's service plan, provided treatment for the resident's rash, and added interventions after the resident falls.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/06/2023
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NAME OF PROVIDER OR SUPPLIER LEXINGTON POINTE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3385 DISCOVERY ROAD EAGAN, MN 55121
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL366514956C/#HL366513042M #HL366516004C/#HL366513664M</p> <p>On July 5, 2023 through July 6, 2023, 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 163 active residents, 43 of whom received services under the Assisted Living with Dementia Care license.</p> <p>No correction orders are issued for #HL366514956C/#HL366513042M.</p> <p>The following correction order is issued for #HL366516004C/#HL366513664M, tag identification 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360	No plan of correction is required for this tag.	