DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305687068M
Compliance #: HL305683454C

Date Concluded: April 5, 2024

Name, Address, and County of Licensee Investigated:
Lakeview Assisted Living
941 10th Street
Heron Lake, MN 56137
Jackson County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Inconclusive

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 assess a resident after a change in condition and failed to develop and implement interventions to prevent skin breakdown.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to a lack of documentation and conflicting information provided, it was unable to be determined if neglect occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, death record, facility incident reports, staff schedules, and facility policies and procedures. Also, the investigator observed activities of daily living and wound care at the time of the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and osteoporosis. The resident's service plan included assistance with dressing, toileting, bathing, medication administration, and safety checks. The resident's assessment indicated the resident required assistance with transfers and walking. The assessment also noted the resident did not have impaired skin integrity.

Three months after her admission to the facility, the resident experienced a decline in health status. Facility staff assessed the resident and determined she required additional assistance with cares and transfers. The assessment indicated the resident required the assistance of two staff and a mechanical lift for transfers, was unable to walk, and required assistance with propelling her wheelchair. No skin concerns were noted on the assessment.

The resident's service plan was not updated to reflect the change in condition or the need for additional services; however, staff were notified and aware of the resident's decline and provided care in accordance with the updated assessment of the resident's needs.

Approximately two weeks later, staff documented a reddened area on the resident's back, but the resident's medical record lacked any further description or assessment of the area. The resident died three days later.

The resident's record did not include evidence that hospice services were discussed with the resident or the resident's family, and the resident did not receive hospice services prior to her death. However, the resident's family was aware of the resident's decline in health status and were present at the time of the resident's death.

During interviews with facility staff, staff acknowledged the resident had an area of skin breakdown, but stated they applied ointment to the area to prevent further skin breakdown. Facility staff indicated they were aware of the resident's decline in condition and need for additional assistance.

During an interview, a facility nurse acknowledged the resident's service plan was not updated after her decline in health status, but indicated the resident was assessed and staff were aware of the resident's need for additional assistance and care was provided in accordance with the resident's needs.

Attempts to contact the resident's family were unsuccessful.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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; resident deceased.
Family/Responsible Party interviewed: Attempts to contact were unsuccessful
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
	30568	A. BUILDING: _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW ASSISTED LIVING	**941 10th STREET HERON LAKE, MN 56137**

(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 February 6, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL305683454C/#HL305687068M. No correction orders are issued.	0 000		