Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL207055941M
Compliance #: HL207058437C

Date Concluded: November 8, 2024

Name, Address, and County of Licensee Investigated:
Emerald Crest of Minnetonka
13417 Lake Street Extension
Minnetonka, MN 55305
Hennepin County

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

Evaluator's Name: Lisa Coil, RN, BSN
Special Investigator

Finding: Substantiated, individual 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 resident obtained an injury of unknown cause. The resident obtained a large, deep laceration to her right elbow area which required medical attention.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. An individual alleged perpetrator, who was an unlicensed caregiver, was responsible for the maltreatment. The alleged perpetrator failed to follow the resident's service plan and complete reassurance checks on the resident through the night shift. The resident was not checked on until early the following morning, at which time the injury of unknown cause was found.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. The

investigation included review of the resident record, hospital records, facility internal investigation, personnel files, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with bed mobility, transfers, toileting, and completing reassurance checks. The resident's assessment indicated the resident was alert and oriented, able to make needs known, and had short-term memory loss.

Early one morning, the progress notes indicated an unlicensed caregiver called a nurse to report the resident had a "really large" deep skin tear on the right elbow, which was not bleeding at the time. The note indicated the caregiver was unsure when or how the resident sustained the skin tear. The nurse who received the call notified a hospice nurse who would send someone to the facility to assess the wound.

Later the same day, progress notes indicated the resident was sent to the emergency department for treatment of the wound. The note indicated the resident required sutures for her arm and the resident returned to the facility.

The facility conducted an internal investigation whose documents indicated the skin tear was found by the alleged perpetrator at the end of her night shift and she notified the on-call nurse. The documents indicated management staff member(s) reviewed camera footage, which showed did not check on the resident throughout the shift as the resident's care plan indicated to do so.

Internal investigation interviews with caregivers, completed by management, indicated the resident did not have a skin tear at bedtime the evening prior. The notes from the interview with the alleged perpetrator indicated camera footage showed the alleged perpetrator sleeping during her shift and that when asked if she had been sleeping, she said "yes".

During an interview, an unlicensed caregiver stated he was assigned to float from multiple locations the night of the incident. The caregiver stated he was in the resident's location for about an hour earlier that night and did not return until the alleged perpetrator called for assistance early the next morning. The caregiver stated the alleged perpetrator called for help to assist the resident to the bathroom and with bleeding from the resident's hand. The caregiver stated the resident had a "big skin tear" and the alleged perpetrator had not notified the nurse, so he did.

During an interview, a manager stated camera footage was reviewed for the overnight shift and there was no movement seen for a period of time even though there were scheduled tasked due. The manager stated she is confident the resident was not checked on by the alleged perpetrator until right before the end of her shift.

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: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, attempts were unsuccessful

Action taken by facility:
The facility investigated the incident. The employee is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20705	A. BUILDING: _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF MINNETONKA	13417 LAKE STREET EXTENSION MINNETONKA, MN 55305

(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: #HL207058437C / #HL207055941M On October 7, 2024, 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 33 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL207055941M, tag identification 2360.	0 000	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		