Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL208699082M
Compliance #: HL208692640C

Date Concluded: June 24, 2026

Name, Address, and County of Licensee Investigated:
Silvercrest Properties LLC
6501 Woodlake Drive
Richfield, MN, 55423
Hennepin County

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

Evaluator's Name: Angela Vatalaro, 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 alleged perpetrator (AP) neglected the resident when the AP failed to follow the resident's plan of care. The AP failed to conduct the resident's scheduled safety check. As a result, the safety check was delayed. The resident experienced a vomiting episode and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The AP completed the scheduled once daily "I'm Okay" safety check however it was late. The resident was found lying in bed, had vomited with his CPAP mask was filled with vomit, and the resident also had a bowel movement episode in bed. It could not be determined when the resident's episodes occurred or how long the resident was in bed in this condition. The resident was hospitalized for treatment for aspiration pneumonia.

The investigator conducted interviews with facility staff members, including administrative staff, unlicensed personnel and nursing staff. The investigation included review of the resident records, hospital records, a personnel file, staff schedules, related facility policy and procedures. Also, the investigator observed the facility and conducted onsite interviews related to the facility's safety check practices.

The resident resided in an assisted living facility. The resident's diagnoses included sleep apnea. The resident's service plan included assistance with one time daily "I'm Okay" check and monthly vital signs. The resident's assessment indicated the resident was independent with activities of daily living and independently used a walker and/or cane in his apartment. The resident toileted himself independently and would use the call pendant if he needed assistance. The resident independently managed his CPAP machine. The resident was active in the wellness center, did activities, and tried to attend every day. The resident was occasionally disoriented, had forgetfulness, and memory impairment.

The resident's scheduled services record indicated the resident had a daily 8:00 a.m. scheduled "I'm Okay" safety check. The service was documented as completed daily by staff during the month of the incident. On the day in question, the AP documented when she went into the resident's room, the resident was lying down in his bed with the blanket over him. His floor had vomit and there was an odor. The resident did not state what happened. The resident was provided a shower, and the nurse was notified.

At 12:40 p.m., the resident's progress notes indicated the facility reached out to family to inform them of the resident's incident. The resident had thrown up and had a bowel episode in bed. There was vomit in the resident's CPAP tubing and mask. The resident was showered, and emergency medical services (EMS) were called.

At 12:47 p.m., an EMS report indicated dispatch was notified. Upon arrival, the resident was sitting on the toilet without difficulty, was being cleaned up by staff, and staff were cleaning up the resident's room. Staff check on the resident in the morning. This morning the resident was found in bed, covered in feces, vomit, and the resident's CPAP was covered in vomit. The resident was acting altered. The resident was usually able to walk with a walker, however now the resident could not stand without difficulty and needed help walking. The resident spoke to family the day before at 5:30 p.m. At that time, the resident did not complain about anything nor talk any differently than usual.

Emergency room records indicated when the facility staff checked on the resident at 12:00 p.m., they found the resident covered in vomit and diarrhea. The CPAP mask was filled with vomit. The last known well-being time for the resident was the day before at 5:30 p.m. The resident admitted to the hospital for treatment of right lung aspiration pneumonia due to vomiting.

Progress notes indicated from the hospital; the resident transferred to a transitional care unit (TCU). After the TCU stay, the resident discharged back to the facility.

The resident's discharge summary indicated the resident eventually discharged from the facility at his baseline for unrelated reasons.

An email from leadership indicated the AP signed off on the resident's "I'm Okay" safety check task at 1:25 p.m. The charting time and the time of the actual service did not align. There were no cameras overseeing the area, so the facility was unable to validate the time the AP entered the resident's room.

During an interview, the AP stated she did complete the I'm Okay" safety check however it was not on time. It was scheduled at 8:00 a.m. The safety check was visually seeing the resident to ensure safety. The AP stated other residents' services were taking longer and she could not make it to the resident's room on time. The AP stated she was on resident's floor, she did not see the resident in the hallway and thought he must be at breakfast. The AP stated she did not see the resident at breakfast, attempted to look for him in the building, and got distracted. Typically, after breakfast the resident would be at activities. When she did the safety check around 11:00 a.m. or 12:00 p.m. she found the resident in bed lying in vomit and diarrhea. The vomit on the floor was dry. The AP assisted the resident with showering and called the nurse.

During an interview, leadership stated an "I'm Okay" safety check was staff laying eyes on the resident.

During an interview, a nurse stated the services the resident received was a one-time daily "I'm Okay" safety check and monthly vitals. The resident was primarily independent. The resident knew how to and was able to use his call pendant. The nurse stated she got a call the resident had an episode of vomiting and a bowel movement episode. When she responded to the resident's room, the resident was alert, and the resident was getting assistance with showering. The nurse said there was moist/wet vomit observed in the resident's CPAP mask and tubing. Vomit was also on his bed and floor. The nurse stated the AP did not perform the resident's daily safety check correctly. There was an hour before and one hour after the scheduled service time [8:00 a.m.] to complete the task. The AP conducted the safety check midday. When the AP found the resident in his bedroom with vomit and a bowel movement episode, the AP alerted the nurse. The resident transferred to the emergency room. The nurse said she did not know when the vomiting episode occurred.

During an interview, the resident stated he did not have prior concerns with staff checking on him at the facility. Staff checked on him daily. The resident said he did not remember what time he vomited the day he transferred to the emergency room. He also mentioned a timeframe between 1:00 am and 5:00 a.m.

During an interview, a family member stated the resident's check would be done when he went down to meals, or when facility staff seen the resident up and about. If staff went to the resident's room and he was not in there that meant he was up and about. The resident went to activities and went for exercise. The day of the incident, the resident vomited into his CPAP, got the mask off, and then threw up on the side of his bed. The resident got up to go to the bathroom, slipped, decided he could not go anywhere, and went back to bed. The day in question, facility staff did not check on him in the morning and the resident did not go to breakfast. The resident did not have his call pendant around his neck. Staff checked on the resident around 12:00 p.m. and found the resident in his bedroom. The resident's apartment door did not open until then. The resident's room/apartment consisted of a living room area, a full kitchen that he did not use, a bedroom, and bathroom. The resident kept his bedroom door closed when he went to bed. The resident's bedroom door remained closed until facility staff found him. There were no prior concerns about staff not conducting the check on the resident. The family member believed this was a one-time incident. After the incident, the resident was checked every morning.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Once the resident was found in his bedroom, facility staff cleaned the resident up and coordinated transfer to the emergency department. The AP no longer worked at the facility.

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
	20869	A. BUILDING: _____ B. WING _____	C 06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	6501 WOODLAKE DRIVE RICHFIELD, MN 55423

(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 June 3, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL208692640C/#HL208699082M. No correction orders are issued.	0 000		