

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL232175923M
Compliance #: HL232171126C

Date Concluded: January 8, 2024

Name, Address, and County of Licensee

Investigated:

Regent at Burnsville
14500 Regent Lane
Burnsville, MN 55306
Dakota County

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

Evaluator's Name: Lissa Lin, 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 alleged perpetrator (AP) neglected the resident when she fell out of her wheelchair and suffered spinal fractures.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglected was not substantiated. The AP followed the resident's service plan which required staff to use a wheelchair when transporting the resident. The AP escorted the resident back to her room in a wheelchair when she suddenly fell forward, face down onto the floor, injuring her face and spine.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of medical records, policies and procedures and video of the fall. Also, the investigator observed staff members transporting residents in wheelchairs.

The resident resided in assisted living. The resident's diagnoses included narcolepsy with catalepsy, osteoarthritis, and repeated falls. Narcolepsy with catalepsy is a sleep disorder with excessive daytime sleepiness, sleep paralysis, hallucinations, and sudden loss of muscle tone.

The resident's service plan included assistance with toileting, showering and escorting her to the dining room for meals in a wheelchair. The resident's assessment indicated she had a history of multiple falls in the same manor without injury due to spontaneity, and poor decision making. She was vulnerable due to inability to walk safely. She was oriented to person.

One evening, the AP transported the resident by wheelchair, from the TV room to her room to get ready for bed. As the AP transported her down a hallway, the resident fell forward from the wheelchair and landed face down on the carpeted floor. The AP stayed with the resident and called for help. The nurse assessed the resident and called 911. Paramedics transported the resident by ambulance to the emergency room for evaluation and treatment. The resident admitted to the hospital with a head laceration and cervical spine fractures which required a cervical collar and surgery. The facility notified her family and physician.

The resident's family member provided an undated, no audio, video clip of the resident's fall. The video clip showed the AP transporting the resident in a wheelchair. The resident leaned slightly to her right side, then abruptly fell forward, and landed face down on the carpeted floor. The AP ran around the wheelchair toward the resident. The video ended. Due to the video quality and lighting it was unclear where her feet were when she fell.

During an interview, the AP said the resident had a standard wheelchair with footrests. He said the resident had been in the TV room watching a program with several other residents when she started "behaviors" that usually meant she was tired. The AP asked her if she wanted to get ready for bed and the resident said yes. The AP transported the resident from the TV room towards her room. They were about 25 feet from her room when she suddenly pitched forward and fell out of her wheelchair. He saw blood on her head and screamed for help. The AP said it happened so fast he had no warning. He thought she may have moved one of her feet and it went under the wheelchair.

During an interview, a nurse manager said she reviewed the video, and all interventions were in place. The nurse manager said the resident fell out of the wheelchair unexpectedly and it looked like one of her narcolepsy incidents because she appeared to go limp as she fell.

During an interview, the resident's family member said the fall was an accident and not the AP's fault. The resident had narcolepsy for decades and recent increased dementia issues made her a fall risk. She wished the facility could have used a wheelchair restraint to secure the resident, but realized restraints are not allowed. The family member said the resident was hospitalized and had spine surgery, which went well. The family member said the resident is back to her baseline physical health and moved to a new facility specializing in dementia cares. The family member said the facility provided good care while the resident lived there.

A nurse who assessed the resident after the fall did not return multiple phone calls for an interview.

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, moved to different facility and cognition issues.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility had interventions in place and sent the resident to the hospital. The facility conducted an internal investigation.

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: 23217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2023
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NAME OF PROVIDER OR SUPPLIER REGENT AT BURNSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 14500 REGENT LANE BURNSVILLE, MN 55306
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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>#HL232173882C/HL232177306M, HL232171126C/HL232175923M, and HL232177104C/ HL232179346M.</p> <p>On December 5, 2023 through December 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 139 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL232173882C/HL232177306M#, tag identification 470.</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>	
0 470 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for</p>	0 470		

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

Minnesota Department of Health

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0 470	<p>Continued From page 1</p> <p>determining its staffing level that:</p> <ul style="list-style-type: none"> (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <ul style="list-style-type: none"> (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; <p>This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to ensure the facility could respond promptly and effectively to individual resident emergencies when developing the licensee staffing plan. Two of two memory care residents, (R2 and R5) choked during meals when one staff was assigned in the dining room which required staff to perform the Heimlich maneuver, yet also try to contact other staff in the facility to call for emergency assistance or</p>	0 470		

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0 470	<p>Continued From page 2</p> <p>services. This had the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2 R2 lived in the memory care unit. Her diagnoses included malignant salivary gland cancer, brain cancer and dementia. R2's service agreement dated July 10, 2023, indicated she received assistance with activities of daily living. There was a delegated unlicensed personnel (ULP) task to document if R2 ate breakfast and add an unscheduled service for times she had breakfast. R2 had a regular diet with thin liquids.</p> <p>R2's progress notes dated July 10, 2023, at 12:29 p.m., indicated the hospice nurse was at facility to admit R2 to hospice. At 6:54 p.m, director of health services (DHS)-A arrived at R2's apartment after getting called to the memory care unit. R2 was seated in her wheelchair, slumped over with no audible or palpable apical pulse, no respiratory effort. Oximeter reading was 66% and falling. Emergency medical services (EMS) arrived, given report R2 was DNR (do not resuscitate), was just evaluated for hospice and would have been admitted to hospice. R2's time of death noted as 12:45 p.m.</p>	0 470		

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0 470	<p>Continued From page 3</p> <p>The licensee "Internal Investigation of Incident" dated July 10, 2023, at 12:38 p.m., indicated R2 was suspected of choking due to noted distress while eating lunch in the common area. ULP-G performed the Heimlich maneuver until R2 slumped over with little response. ULP-G then stopped performing the Heimlich. R2 was eating lunch around 12:20 p.m.; she had soup and her entree. R2 noted to be in distress at 12:35 p.m. and ULP-G started Heimlich. ULP-G also made calls to nursing and front desk at 12:38 p.m. Staff arrived in unit at 12:40 p.m. ULP-G left unit at approximately 12:42 p.m. with no report given to care team.</p> <p>Review of a licensee untitled, undated document indicated camera footage was reviewed and ULP-G performed the Heimlich maneuver until R2 became unresponsive. ULP-G called nursing and front reception to get help but she was crying and unable to communicate what was needed. Nursing staff and other staff arrived at the unit.</p> <p>During an interview on January 5, 2024 at 9:18 a.m., ULP-G said the day R2 choked was the first time the nurse was not close by. ULP-G said she was reheating R2's soup, she began eating soup and bread, when one of the residents said R2 needed help. ULP-G said she began the Heimlich, tried to move R2 in her wheelchair with her elbows and call the front desk for help. ULP-G dropped the phone twice trying to call. ULP-G said she was crying and told the front desk staff to send help. ULP-G said she was trained to do the Heimlich and did her best.</p> <p>During an interview on January, 2024 at 8:32 a.m., registered nurse (RN)-K said she was orienting a new staff member when the regular desk phone rang. It was around noon and</p>	0 470		
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0 470	<p>Continued From page 4</p> <p>whoever called was crying or laughing "weird". RN-K said hello a few times with no answer, so she hung up. She told the new staff member someone must have "butt dialed" her. RN-K said front desk staff called her and said she had to go to memory care right away but did not give a reason why. RN-K said when she arrived at the memory care unit ULP-G was on the floor crying and hysterical and then ran out of the unit.</p> <p>R5 R5 lived in the memory care unit. Her diagnoses included unspecified dementia. R5's service plan signed December 1, 2023, indicated since April 21, 2023 she received daily meal monitoring by staff to support adequate intake. R5 had a regular diet.</p> <p>A progress note dated November 28, 2023, at 1:06 p.m., indicated an emergency page went out from memory care that nursing was needed right away. R5 choked on pizza crust during lunch. ULP-J performed the Heimlich maneuver and with the second abdominal thrust the crust was expelled. EMS arrived to assess R5 and determined she did not need to go to the emergency room. The nurse assessed R5 and contacted her provider and family. Staff continued to monitor R5 as she ate dinner without incident.</p> <p>During an interview December 5, 2023, at 10:55 a.m., ULP-J said she is regularly scheduled to work in memory care and the staff ratio is one staff for five residents. ULP-J said she performed the Heimlich on R5 during the past week when she choked on a pizza crust. ULP-J said it was scary but she was trained to do the Heimlich, then called the manager.</p> <p>A policy titled Staffing, dated March 28, 2023,</p>	0 470		

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0 470	<p>Continued From page 5</p> <p>indicated the staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week and will be adequate to address the residents' scheduled and reasonable unforeseeable unscheduled needs given the physical layout of the facility.</p> <p>A policy titled Direct-Care Staffing Plan, dated April 6, 2023, indicated the adequate number of staff is determined by the scheduled services in independent and assisted living in each memory care suite at a 1:5 staffing ratio, and care suites at a staffing ratio of 6 or 7 residents.</p> <p>A policy titled Food and Nutrition Services, revised January 16, 2023, did not address mealtime staffing ratios.</p> <p>TIME PERIOD TO CORRECT: Seven (7) Days</p>	0 470		