Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL239826622M
Compliance #: HL239829847C

Date Concluded: February 3, 2025

Name, Address, and County of Licensee Investigated:
Sunrise of Golden Valley
4950 Olson Memorial Highway
Golden Valley, Minnesota 55422
Hennepin County

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

Evaluator's Name: Nicole Myslicki, RN
Special Investigator
Rhylee Gilb, RN
Special Investigator

Finding: Substantiated, facility 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 alleged perpetrator (AP) neglected the resident when the AP left the resident alone to eat lunch. The resident choked on food and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had requested a change from thickened liquids to regular consistency liquids due to quality of life but maintained difficulties swallowing due a medical condition. The facility nursing assessment indicated he needed supervision and cues during meals for meal safety. The facility failed to implement the required meal supervision service and directives to unlicensed personnel (ULP) for cues during meals. ULP interviewed stated he ate independently. The AP was not responsible for maltreatment. The AP followed the plan of care provided by the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the provider, and dietitian. The investigation included review of the resident record, death record, home health agency records, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed a meal and staff assisting residents to eat.

The resident resided in an assisted living facility. The resident's diagnoses included dysphagia (difficulty swallowing) from a rare neurodegenerative disorder. The resident's assessment identified under the activities of daily living section; the resident was independent with the physical function of eating. The assessment also identified choking and swallowing issues as nutritional risk factors. The assessment indicated interventions in place for the risk factors included encouraging him to eat in an upright position, to eat slowly, and to chew each bite thoroughly before attempting to swallow. Staff were to encourage him to use spoons for eating and discourage him from using straws. Additional interventions in place included observing the resident's dining needs and report changes to the provider.

The resident's service plan was reflective of the nursing assessment identifying the resident as independent with the function of eating. However, the service plan also included the resident's assessed eating safety needs and included assistance cues with alternating small bites of food with sips of beverages, sit in an upright position, eat slowly, use spoons and avoid straws. The service plan indicated the resident required observation of dining needs and report any changes in meal intake or tolerance to the diet. The service plan also included assistance with observing and reporting any signs or symptoms of swallowing changes or difficulty tolerating the diet, including coughing or delayed swallowing. The service plan was signed and dated by the resident's family member and the nurse.

The resident's orders included an order to discontinue nectar thickened liquids, and the resident requested thin liquids. The order indicated the provider discussed risks with the resident and spouse who wanted thin liquids for quality of life. The provider changed the resident's diet orders to regular consistency and texture diet and thin liquids.

The resident's service delivery record showed under each meal service the facility failed to include directive to ULP for the resident's meal safety cues and failed to indicate the resident required observation and supervision with meals to provide cues. The service delivery record required ULP to identify what level of assistance the resident required and where the resident ate. The service delivery record indicated the resident had been eating meals independently in his room consistently for each meal throughout the month leading up to the incident. The service delivery record on other services inappropriately directed ULP to identify what level of assistance the resident required on each shift, instead of directing what level of assistance the resident needed as determined by the nursing assessment.

A nursing note indicated the AP (an ULP) found the resident unresponsive when they went into his room to collect his meal tray. The AP called a nurse who came and assessed the resident. The resident was not breathing and had no pulse. The resident was slumped over to his left side with his mouth open and saliva coming out of his mouth. A second nurse assessed the resident as well; verified he was not breathing and without a pulse. Staff called emergency medical services (EMS) who pronounced him deceased.

The resident's death record identified cause of death due to lack of oxygen from food blocking the airway.

An image of the resident's meal tray included a plate with sliced sausages and sauerkraut. The plate also included bowls of fresh fruit and cottage cheese, each individually covered in plastic wrap, as well as plastic spoons and forks.

During investigative interviews, staff members stated the resident did not receive assistance eating meals.

During an interview, the licensed assisted living director (LALD) stated the interventions in the resident's plan should have been removed when his diet changed back from thickened liquids to regular liquids due to quality of life. The LALD stated the facility did not complete an internal investigation or incident report because they just thought it was an unexpected death. The facility did not learn about the resident's cause of death until the following month.

During an interview, the nurse stated the resident fed himself. The nurse stated the service plan should have been changed and the resident "probably" would not have wanted assistance. The nurse stated she did not know why the service plan included services for assistance and observation with meals.

During an interview, the AP stated she had not been told the resident needed assistance with eating when she started. The resident asked for help cutting food as needed, but he ate by himself. The day of the incident, the AP took the resident's lunch tray to his room. The resident sat in his wheelchair and told the AP thank you. Less than one hour later, the AP went back to collect the meal tray. The AP saw the resident leaning onto one side in his wheelchair. The AP thought the resident had been asleep and did not want him to fall, but he did not respond when she called his name. The AP notified nursing who decided to call EMS.

During an interview, a family member stated she did not think facility staff were honest with her when they said he had not been hungry for lunch. They were adamant he did not eat anything. Staff were supposed to make sure his food was in small, bite sized pieces, and assist him in taking small bites and drink water while eating.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility and the AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP followed the facility directive and/or policies and procedures.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility called 911 and the family.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Golden Valley Police Department
Golden Valley City Attorney
Hennepin County Attorney
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23982	A. BUILDING: _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF GOLDEN VALLEY	4950 OLSON MEMORIAL HIGHWAY GOLDEN VALLEY, MN 55422

(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: HL239829847C/HL239826622M On December 3, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 44 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL239829847C/HL239826622M, tag identification 1640, 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.	
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement services required by the service plan for one of one residents (R1) with records reviewed. R1 required reminders and supervision with eating. R1 ate a meal alone in his room, choked and died. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01640		

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01640	Continued From page 2 situation has occurred only occasionally). The findings include: R1 admitted to the licensee March 15, 2023. R1's diagnoses included dysphagia. R1's service plan dated August 8, 2024, signed by registered nurse (RN)-A, indicated R1 received assistance with encouraging him to eat in an upright position, to eat slowly, and to chew each bite thoroughly before attempting to swallow. The service plan indicated R1 required observation of dining needs and report any changes in meal intake or tolerance to the diet. The service plan also included assistance with observing and reporting any signs or symptoms of swallowing changes or difficulty tolerating the diet, including coughing or delayed swallowing. R1's nursing assessment dated May 1, 2024, indicated R1 received regular textured foods and nectar-thickened liquids. The assessment identified R1 as having swallowing concerns. The assessment indicated staff would encourage and assist R1 to alternate small bites with sips of beverages, to use spoons for eating, discourage him from using straws, and observe his dining needs and report to the provider and changes in meal intake and or tolerance to the diet. Additionally, the assessment indicated staff would observe and report any signs or symptoms of swallowing changes or difficulty tolerating the diet, including coughing or delayed swallowing. R1's service delivery record for October, 2024, indicated R1 ate independently, without supervision, in his apartment the days leading up to the incident. The service delivery record showed under each meal service the facility failed	01640		

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01640	Continued From page 3 to include directive to unlicensed personnel (ULP) for R1 ' s meal safety cues and failed to indicate R1 required observation and supervision with meals to provide cues. The service delivery record on other services inappropriately directed ULP to identify what level of assistance R1 required on each shift, instead of directing what level of assistance R1 needed as determined by the nursing assessment. A statement written and signed by licensed assisted living director (LALD)-B, dated October 10, 2024, indicated on October 9, 2024, an ULP found R1 deceased, and staff were calling 911. The AP brought R1 his food at 11:45 a.m. and returned around 12:23 p.m. to get his plate but found him deceased in his chair. Emergency medical services (EMS) arrived on scene and pronounced him deceased at 12:43 p.m. R1's death record identified his cause of death as food bolus asphyxia. During an interview on December 18, 2024, at 8:33 a.m., R1's family member (FM)-G stated staff were supposed to make sure R1's food was in small, bite sized pieces, and assist him in taking small bites and drink water while eating. During an interview January 2, 2025, at 9:02 a.m., LALD-B stated the instructions in the service plan should have been removed when he no longer had an order for thickened liquids. During an interview January 2, 2025, at 10:07 a.m., ULP-D stated no one told her R1 needed assistance eating when she started. R1 would ask for help as needed to cut his food, but he fed himself. On October 9, 2024, ULP-D brought R1 his lunch around 12:00 p.m. ULP-D left and	01640		

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01640	Continued From page 4 returned around 12:45 p.m. to collect his tray. ULP-D found R1 sitting in his wheelchair, leaning to one side. ULP-D began calling for him, worried he would fall. As ULP-D walked closer, she noticed food coming out of R1's mouth. During an interview January 2, 2025, at 11:32 a.m., RN-A stated the service plan should have been changed. R1 did not receive assistance and fed himself. RN-A stated R1 probably would not have wanted assistance and had been non-compliant with diet changes in the past. RN-A did not know why the service plan included the services indicating R1 needed assistance or observation with meals. The licensee's policy titled Individualized Service Plans (Addendum), dated August 19, 2021, indicated the service plan would be developed based on the resident's assessed needs. The policy also indicated the RN would review, change, and update the service plan as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag.	

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02360	Continued From page 5 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		