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 #: HL239827484M
Compliance #: HL239824054C

Date Concluded: January 2, 2024

Name, Address, and County of Licensee Investigated:
Sunrise of Golden Valley
4950 Olson Memorial Hwy 211
Golden Valley, MN 55422
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 provide cares such as wound cares and timely call light response.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Though a call light malfunction did occur, the facility took steps to address the issue. The resident did have a history of pressure ulcers prior to admission to the facility

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 resident's records, and facility's policies and procedures. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety disorder and kidney failure. The resident's service plan included assistance of two persons and Hoyer lift for transferring or a pivot transfer. During the resident's stay at the facility, she was enrolled in Hospice who also participated in her cares, particularly wound care.

Concerns regarding the resident's cares included an occasion when it was reported it the staff members four hours to respond to the call light, resulting in the resident being unable to use the toilet. Another concern was that the facility staff members did not turn the resident every two hours as specified in the care plan and developed she developed pressure sores.

During the 3rd month after admission, the resident's assessment indicated the resident had the wound on her sacrum that had been present since the admission.

During the 4th month after admission, the facility completed a change-of-condition assessment, which indicated the resident sustained a skin tear on the right lower leg and a bruise left lower leg. The same document indicated a pressure wound had healed.

During the 5th month after admission, the resident's progress notes indicated the facility continued to coordinate cares with hospice. For instance, the resident developed a reddened area on her skin, which was addressed with hospice and a barrier cream.

The resident's progress notes included a description an issue with the resident's call light. A facility care coordinator followed up with the family regarding the resident being left sitting at the edge of the bed for around three hours in which the call light did not work and notify staff members of the resident's need for assistance. In response to this, the care coordinator provided the resident with a new call light and educated the staff not to leave the resident unattended during care.

During an interview, the care coordinator stated the resident's dementia had been progressing. He recalled when he began working, the resident already used a hoyer lift for transferring. The coordinator acknowledged an issue with the call light system, where the resident's call light did not register in the monitor, resulting in unrecorded calls and missed notifications for assistance. Upon being informed by the family, he promptly provided a new pendant, resolving the issue on the same day. The family expressed concerns about the resident not receiving the expected care, citing issues such as delayed response to the call light, and non-use of the Hoyer lift. These concerns were thoroughly explained and brought to the attention of the director to facilitate a proper solution. The coordinator noted the resident's fluctuating health, occasional preference for using the commode instead of the Hoyer lift, and adjustments to the plan of care based on the resident's daily condition. He said staff check on the resident every 2-3 hours or more frequently, depending on the frequency of call light usage and a care conference was held monthly to address the family's concern as well.

During the interview, the nurse #1 stated the hospice nurse visited the resident three times a week, addressing a wound on the resident's lower leg and providing necessary orders. Per the resident's care plan, staff checked on her two to four times during their shift and as needed when she activated her call lights. Due to her escalating care needs, more time and assistance were required. The husband also actively pressed the call light on the resident's behalf, resulting in frequent staff visits. The use of the Hoyer lift became necessary, though she often had reservations and required reassurance. On one occasion, the resident mistakenly claimed no one was there to help, despite the registered nurse and her husband being present. The registered nurse acknowledged a period of short staffing when it took longer to respond to the call light, but efforts were made to answer as promptly as possible. However, she did not know the specific duration it took for staff to respond to the call light.

During an interview, nurse #2 stated the resident had a Hoyer lift and she did not like to use it. She also confirmed the resident had a skin tear and the hospice nurse took care of it, considering the facility was not a skilled care facility.

The attempts to interview a family member were not successful.

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. The resident was deceased.
Family/Responsible Party interviewed: Attempted but unsuccessful
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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
	23982	A. BUILDING: _____ B. WING _____	C 11/30/2023

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 On November 30, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL239827484M/HL239824054C. No correction orders are issued.	0 000		