

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240107683M
Compliance #: HL240103162C

Date Concluded: February 27, 2025

Name, Address, and County of Licensee

Investigated:

Sunrise Senior Living of Minnetonka
18605 Old Excelsior BLVD
Minnetonka MN 55345
Hennepin County

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

Evaluator's Name: Maggie Regnier
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 alleged perpetrator (AP) abused the resident when she used a small couch to block a door and confined the resident to her room at night.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP, an unlicensed caregiver, placed a couch across the resident's apartment doorway confining her to the apartment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, residents and visitors.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cognitive communication deficit, hearing loss, anxiety disorder, repeated falls and generalized weakness. The resident's service plan included assistance with all grooming, dressing and toileting activities, medication management and reassurance when anxious. The resident's assessment indicated the resident was hard of hearing, had a short attention span, confused about her environment, and easily frustrated but redirectable. The assessment also indicated the resident was up frequently at night, history of wandering, and required frequent validation and reassurance but responded to redirection.

A facility document indicated one morning a staff member found a small couch pushed in front of the resident's door to her room. The door was open, but the couch prevented the resident from exiting and confined her to the room. The staff member removed the couch and assisted the resident with her morning routine activities. The document indicated the staff member notified facility leadership of the incident and facility leadership launched an investigation into the incident.

At the time the couch was found blocking the resident's doorway, a picture was taken. The picture showed a couch in the hallway position across the resident's apartment doorway. The back of the couch was towards the apartment and the doorway was entirely blocked. A note with the picture indicated the resident was not able to get out and was asking for help.

A review of the resident's medical record identified no assessment describing a reason an intervention such as a restraint to confine the resident to her room nor did it contain nursing delegation for confining the resident to her room.

During an interview, manager #1 stated when the staff member found the couch confining the resident to her apartment, she removed the obstruction and contacted facility management immediately. Manager #1 stated the facility's internal investigation identified the AP, an unlicensed caregiver, who used the couch to block the resident's doorway.

The facility's internal investigation indicated the resident was in her room calling out for help at the time the couch was moved away from the door. The same document indicated the facility spoke with the AP, an unlicensed caregiver, who said this had not been done before but she thought that if the resident was confined to her room, she might be more inclined to sleep at night. The document indicated the AP said she was not aware this could be a restraint and that she would discontinue the practice.

During an interview, manager #2 stated all staff members are trained prior to providing care, what a restraint is and how to care for a vulnerable adult not using restraints. Manager #2 further stated that other staff members were interviewed after this incident and demonstrated knowledge that placing a couch in the doorway of a resident would be considered a restraint

During an interview, the unlicensed care giver who reported the situation stated she instantly recognized the couch confined the resident to her room and needed to be reported. The unlicensed care giver also stated the resident was at the doorway yelling out for help when she found the resident blocked in the room. The unlicensed care giver also stated the placing a couch in front of the door was not something she had seen before.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: No, cognitive decline

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: No, attempts were unsuccessful.

Action taken by facility: The facility provided staff re-educated to all staff members regarding restraints. The AP was no longer employed at 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.

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>

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

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

Minnetonka Police Department

Minnetonka City Attorney's Office

Hennepin County Attorney Office

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2025
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NAME OF PROVIDER OR SUPPLIER SUNRISE OF MINNETONKA	STREET ADDRESS, CITY, STATE, ZIP CODE 18605 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345
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(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
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0 000	<p>Initial Comments</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>#HL240103162C/#HL240107683M</p> <p>On January 31, 2025, 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 40 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL240103162C/#HL240107683M, tag identification #2360.</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>Tag number #2360 does not itself require a plan of correction as it only serves to document maltreatment occurred at the facility. Please see the public report for details which is sent separately.</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</p>	
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review:</p> <p>The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p> <p>Please refer to the public maltreatment report for details.</p>	02360	<p>Assisted Living Provider 144G. 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</p>	

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