Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319682765M
Compliance #: HL319684663C

Date Concluded: June 15, 2023

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living LLC
3030 Southlawn Drive
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Brooke Anderson, 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 facility neglected the resident when scheduled safety checks were not completed and the resident was found on the floor with a nose fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to conflicting information and documentation, it is unable to be determined if maltreatment occurred. Although the resident's last scheduled safety check was not completed, the safety check was scheduled six hours prior to the time the resident was found on the floor. The time of the resident's fall is unknown, and it is unable to be determined if completion of the safety check would have prevented the resident's fall or injury.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, personnel

files, and facility policies and procedures. At the time of the onsite visit the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, vascular dementia, and history of urinary tract infections (UTI). The resident's service plan included assistance with medication management, toileting, bathing, and safety checks. The resident's assessment indicated the resident was forgetful and confused.

The resident's medical record indicated the resident was found sitting on the floor between her bed and the wall at 8:30 a.m. Staff observed the resident's face was swollen and reddened with a rash-like appearance and the resident was sent to the emergency room for an evaluation.

Hospital records indicated the resident's nose was fractured, she had abscessed teeth, and an ongoing UTI. Hospital documentation indicated the physician was unable to determine if the nose fracture was a new injury. The resident was prescribed two antibiotics and sent back to the facility.

Further review of the resident's facility medical record identified the resident had a safety check scheduled for 2:30 a.m. the morning she was found on the ground. Documentation identified the safety check was completed. However, the staff member who signed off on the safety check was not the staff member who worked that overnight shift.

The staff member who signed off on the safety check was unable to be reached for interview.

During an interview, the staff member who worked the night of the incident stated she did not enter the resident's apartment and was not trained to complete safety checks on the resident. The staff member indicated she did not have her own log-in to the computer system to know what services to provide and never documented on the electronic documentation device.

During an interview, a facility nurse stated no one witnessed the resident fall, but when staff found the resident and noticed the resident's swollen, reddened face, they alerted the nurse. The resident was sent to the emergency room, placed on antibiotics, and returned to her baseline status after the incident.

During an interview, a family member stated the emergency room told her the redness on the resident's face was possibly a skin reaction from the antibiotic she was on at that time for her ongoing UTI. The family member stated she is very involved in the resident's care and satisfied with the care provided at the facility.

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: No, due to cognitive status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility sent the resident to the hospital and investigated the incident.

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
	31968	A. BUILDING: _____ B. WING _____	C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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: #HL319684662C/#HL319682764M #HL319684663C/#HL319682765M On May 4, 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 74 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL319684662C/#HL319682764M, tag identification 2320. No correction orders were issued for, #HL319684663C/#HL319682765M.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards and supervision for two of two residents (R1, R2) with records reviewed. The licensee did not have a system in place to ensure coordination of care upon R1 and R2's return to the facility following hospitalization. The licensee failed to complete an assessment upon R1 and R2's return to the facility. The licensee also failed to complete documentation following R1 and R2's return to the facility and failed to implement hospital discharge orders. R1 and R2 were rehospitalized. 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	02320		

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02320	Continued From page 2 situation has occurred only occasionally). The findings include: R1 R1's diagnoses included vascular dementia, atrial fibrillation, and diabetes type 2. R1's service plan dated July 31, 2022, indicated R1 received assistance with medication management, toileting, dressing, grooming, showers, and safety checks. R1's progress note dated August 11, 2022, indicated R1 was vomiting and had loose stools. Licensed practical nurse (LPN)-C assessed R1, called emergency medical services and R1 was transported to the hospital. R1's hospital record dated August 11, 2022, indicated R1 was diagnosed with bilateral pneumonia, sepsis and required pressors (a medication to increase blood pressure). R1 was transferred to the intensive care unit. R1's hospital record identified R1's anticipated discharge was August 16, 2022. The hospital social worker had problems communicating with the licensee to ensure R1 was able to return. The hospital record indicated R1 discharged back to the licensee on August 17, 2022, via hospital transportation. R1's medical record lacked evidence R1 was readmitted to the facility following hospitalization. R1's medical record lacked a change in condition assessment was completed after R1's hospitalization.	02320		

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02320	Continued From page 3 R1's pharmacy records indicated no medication was dispensed for R1 after August 8, 2022. R1's medication administration record dated August 2022, indicated no medications were administered to R1 for the dates August 17, 2022, to August 20, 2022. R1's hospital record dated August 20, 2022, indicated R1 returned to the emergency room with complaints of nausea and vomiting. R1 was hospitalized for nine days for chronic heart failure, cardiomyopathy (a heart muscle disease), diabetes, and a heel pressure injuryR1's hospital records indicated R1 did not receive medications ordered from prior hospitalization. R1's hospital records indicated R1 was discharged to a different facility on August 29, 2022, following the second hospitalization. R1's medical record lacked evidence that R1 returned to the hospital on August 20, 2022. R1's medical record lacked a discharge summary. During an interview on May 4, 2023, at 2:30 p.m., LPN-C stated R1 was sent to the hospital, returned to the facility for three days and was sent back to the hospital. LPN-C stated the pharmacy entered the medications into the electronic medical record, but LPN-C was unsure why the medications were not administered. An email sent by licensed assisted living director (LALD)-A on May 9, 2023, indicated the licensee did not have a change in condition assessment completed for R1.	02320		

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02320	Continued From page 4 During an interview on May 4, 2023, at 2:30 p.m. director of nursing (DON)-B stated the licensee had a problem with the process when residents returned from the hospital. DON-B indicated documentation should be completed upon a resident's return to the facility, the facility should be available to coordinate care with the hospital and the pharmacy, and assessments and documentation of the resident condition should be completed. DON-B stated the licensee had now implemented an after hours nurse triage agency and completed education at a staff meeting following this incident. R2 R2's diagnoses included acute on chronic congestive heart failure, chronic kidney disease-stage 3, chronic obstructive pulmonary disease, and atrial fibrillation. R2's service plan dated May 17, 2023, indicated R2 received assistance with bathing, laundry, and increased internationalized ratio (INR) management (lab required for blood thinning medication). R2's progress notes dated May 1, 2023, indicated R2 complained of shortness of breath, left chest pain, lethargy, and weakness. R2 was sent to the hospital via ambulance. R2's hospital record dated May 1, 2023, indicated R2 was admitted with acute anemia due to an upper gastrointestinal bleed. R1's hospital record indicated medications orders were changed. R2's progress notes dated May 4, 2023, indicated the hospital planned to discharge R2 on May 3, 2023. There was no additional communication between the licensee and the hospital. R2 was	02320		

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02320	Continued From page 5 found in his apartment and said a friend drove him back to the facility. R2's progress notes indicated medication orders were changed. R2's medical record did not includee a change in condition assessment after hospitalization. R2's progress notes dated May 12, 2023, indicated R2 had complained of dark red stool. R2 was sent back to the hospital for evaluation. R2's hospital record dated May 12, 2023, indicated R2 was diagnosed with a small bowel bleed and hyperkalemia (high potassium). R2's progress notes dated May 15, 2023, indicated R2 returned from the hospital on May 14, 2023. R2's medical record did not include a change in condition assessment after hospitalization. An email sent by DON-B on May 17, 2023, at 3:30 p.m., indicated the licensee should have completed an assessment for R2 after both hospital returns but no assessments were completed. During an interview on May 4, 2023, at 2:30 p.m., registered nurse (RN)-D stated prior to a resident being discharged from the hospital, communication should be initiated and orders obtained. If a discharge from the hospital was planned to occur on an evening or weekend, it is the expectation of the triage nurse to complete the communication and reconcile medication orders. During an interview on May 4, 2023, at 3:30 p.m., LALD-A stated the incident occurred prior to her	02320		

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02320	Continued From page 6 employment at the facility and said the licensee now had tighter control when residents go to the hospital or return from the hospital. The LALD-A stated the licensee wanted to ensure the residents come back to the facility in a safe way. The licensee's Resident Change in Condition or Need policy dated March 29, 2023, indicated a change in condition assessment would be initiated when a resident had been out of the facility for more than 24 hours and when the resident had been in the hospital or emergency department.	02320		