

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL366366664M  
**Compliance #:** HL366362417C

**Date Concluded:** January 23, 2024

**Name, Address, and County of Licensee**

**Investigated:**

Cedar Creek Senior Living  
19131 Taylor Street NE #8  
East Bethel, MN 55011  
Anoka County

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

**Evaluator's Name:** Michele Larson, 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 facility neglected the resident when they failed to ensure staff repositioned the resident according to her service plan and failed to ensure staff routinely offered or assisted her with meals and eating. The resident developed painful pressure sores on her heels, buttocks, and tailbone (coccyx). In addition, the alleged perpetrator (AP), abused the resident when she forced the resident to take medications.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided care to the resident according to the resident's plan of care and as the resident allowed.

The Minnesota Department of Health determined abuse was not substantiated. The AP denied forcing the resident to take her medications. The facility reviewed video footage from the resident's room and determined the AP did not force the resident to take medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed family members and the resident's interdisciplinary team members. The investigator reviewed video footage from cameras located inside the resident's room. The investigator also reviewed the resident's external medical records, personnel files, and the facility's policies and procedures. In addition, the investigator observed resident cares during an onsite investigation.

The resident resided in an assisted living memory care unit. The resident's diagnoses included progressive functional decline related to Parkinson's disease. The resident received hospice services for comfort care. The resident's service plan included assistance with all cares including two-hour turning and repositioning, meal assist of one staff person in the facility dining room, transfers, and toileting assistance. The resident was able to understand others and make her needs known. The resident used a wheelchair and Broda chair (high back chair that provided repositioning) for mobility and required a sling lift for transfers.

The resident's record indicated the resident had a deep tissue wound on the right heel and a small tail bone (coccyx) pressure sore. Preventative measures developed by the facility included bilateral heel protectors, elevating the resident's heels, twice weekly wound care, repositioning, coccyx dressing changes, and barrier cream. The resident often refused repositioning. Although facility staff failed to consistently document attempts to reposition the resident, the record indicated all the resident's pressure ulcers improved.

The resident's record indicated the resident's food intake decreased as the resident's health declined. The resident's food intake was documented as consuming less than 50%, however, the resident's body weight remained stable and slightly above her ideal weight.

When interviewed, the director of nursing (DON) said there were days the resident was alert able to give consent and days when she was non-verbal, and consent was a simple nod. The DON stated the resident's heel and buttock wounds improved. The DON stated the resident required a lot of cares and supervision, stating the facility recommended to family the resident was better suited for an alternate long-term care setting with more services.

When interviewed, the AP denied administering the resident medications when the resident slept. The AP stated she recalled asking to the resident prior to administering the medication and the resident agreed to take the medications.

In conclusion, the Minnesota Department of Health determined neglect and abuse were 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.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

**"Abuse" means:**

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
- (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
- (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
- (4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(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:

- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

**Vulnerable Adult interviewed:** No. The resident was deceased.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36636</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CEDAR CREEK SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19131 TAYLOR STREET EAST BETHEL, MN 55011</b>
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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
0 000	<p><b>Initial Comments</b></p> <p>On October 4, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL366362417C/#HL366366664M. No correction orders are issued.</p>	0 000	<p>Assisted Living Provider 144G.</p> <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>	

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