Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366366924M
Compliance #: HL366361570C

Date Concluded: March 19, 2025

Name, Address, and County of Licensee Investigated:
Cedar Creek Senior Living
19131 Taylor Street
East Bethel, MN 55011
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 to provide appropriate care and services to the resident resulting in a delay of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While staff acknowledge delays in treatment and care did occur, staff continuously monitored the resident's condition and updated the healthcare provider and family when any change in condition was observed. .

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's healthcare provider. The investigation included review of the resident record(s), death record, hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, and related

facility policy and procedures. At the time of the onsite visit, observations were made of the facility environment, staff interactions, and care being provided.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease, occlusion (blockage) and stenosis (hardening) of the left carotid artery, chronic kidney disease (CKD), peripheral vascular disease, and rheumatic mitral valve disease. The resident's service plan included assistance with medication management, ambulation, transfers, and toileting. The resident's assessment indicated the resident had impaired short-term memory, confusion, anxiety, required staff assistance with activities of daily living, (ADLs), used a wheelchair and four-wheeled walker for mobility, and had a history of falls.

Review of the resident's medical record and facility documentation indicated staff monitored the resident's condition and reported any change in condition to the resident's provider. There was no documentation or additional evidence available to support that any delay in treatment or care contributed to the resident's death.

During an interview, the resident's family recognized delays in treatment and care. The family stated even though they had concerns over the delay in treatments and care, facility staff and the resident's provider continued to monitor and update any changes in the resident's condition.

During an interview, an administrative nurse acknowledged some delay in treatment and stated every effort was made to correct the delay, treat the resident as soon as a delay was recognized and monitor the resident's condition.

During an interview, a facility nurse acknowledged there were some delays in care but the facility actively redirected the delays, continuously monitored the resident, and consistently updated the resident's family and provider on the resident's condition.

During an interview, the resident's provider acknowledged that the facility had some delays in treatment; however, changes in the resident's condition were communicated to family and the provider in an appropriate manner and any delays in treatment and care would not have changed the resident's outcome.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility communicated with the resident's provider and family regarding change in condition.

Action taken by the Minnesota Department of Health:
No further action 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
	36636	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK SENIOR LIVING	19131 TAYLOR STREET EAST BETHEL, MN 55011

(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 January 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL366361570C/#HL366366924M. No correction orders are issued.	0 000		