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 #: HL388603783M
Compliance #: HL388604237C

Date Concluded: November 25, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Crystal
3501 Douglas Drive North
Crystal, MN 55422
Hennepin County

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

Evaluator's Name:
Maerin Renee, 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 after the resident fell and staff failed to assess or report the fall. Family later took the resident to the hospital where she was diagnosed with a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had an unwitnessed fall. After the fall, staff assessed the resident and documented the residents fall per protocol. After the resident had complaints of increasing pain, the resident went to the hospital for further evaluation and was diagnosed with a non-operable pelvic fracture. The resident returned to the facility three days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident records, hospital records, the facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included stroke and pelvic fracture. The resident's services included assistance with activities of daily living (ADLs), meals, medication management, laundry, and housekeeping. The resident's assessment indicated the resident had visual difficulties and used a power chair for her primary means of mobility.

An incident report indicated a staff member working a weekend morning shift found the resident on the floor of her room. The resident said she was trying to get something from a drawer, turned, and lost her balance. The resident did not use her call light for staff assistance. Staff took the resident's vital signs and notified the nurse on call. The resident complained of hip pain and staff gave her pain medication. There were no apparent injuries. Staff leadership and the resident's family member were notified.

The resident's progress notes indicated the resident continued to receive Tylenol for hip pain, and the resident stated it was effective in managing her pain. However, after three days the resident complained of increasing hip pain and staff requested an on-site x-ray from her provider. The resident's provider stated they wanted to see the resident in person and informed the residents family. Two days later a bruise on the resident's right buttock formed and the family member took her to urgent care for an x-ray. The resident was diagnosed with a right fracture of the pelvis and sacrum. A physical therapy (PT) evaluation indicated the resident was weightbearing as tolerated. The resident was discharged from the hospital after three days and did not complain of pain when sitting. Her care was increased to assist of two for transfers and assist of one for ADLs. The resident and staff were educated about her new care plan.

The resident's hospital record indicated the resident was diagnosed with right-sided superior and inferior pubic rami fractures and a sacral fracture. The orthopedic team was consulted and recommended nonoperative management with weightbearing as tolerated on her right leg. No further orthopedic interventions were planned. The resident's pain was well-controlled, although it did increase with movement. After three days, the resident returned to the facility.

The resident's care plan indicated after she returned from the hospital, reassurance checks were initiated once per shift. The resident's care sheets indicated the reassurance checks were completed by staff as directed.

When interviewed, an unlicensed staff member said she was curious when she did not see the resident out in the community bright and early in the morning as usual. She checked on the resident in her room and found her on the floor. The resident was not wearing her pendant, so she had been unable to call for help. The staff member assessed the resident, took her vital signs, and asked if she was in pain. At that time, the resident did not complain of pain, nor did she feel she needed further medical intervention. The staff member notified the on-call nurse

and stated the resident did not start to complain of pain until after the weekend, when staff noticed a bruise had begun to develop around her right hip.

When interviewed, facility leadership stated staff on site followed appropriate protocol after the resident fell, and the resident did not start to complain of much pain until several days later. As the resident complained of increasing pain, and a bruise began to develop around her right hip, nursing attempted to schedule an in-house x-ray for the resident, but the resident's provider wanted the resident seen in person. The resident's family member then took the resident to urgent care to obtain an x-ray of her right hip. At that point, the resident was admitted to the hospital with non-operable pelvic fracture. The resident returned from the hospital after a few days and the facility increased her services considering her new diagnosis.

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: Yes, attempted.
Family/Responsible Party interviewed: Yes, family provided a brief informal statement.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility assessed the resident after the fall, notified her family, and managed her pain. The facility reported increased pain and bruising to the family, initiating the resident's visit to urgent care. The resident's care plan was updated after her hospital stay and staff were trained regarding the resident's increased needs.

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
	38860	A. BUILDING: _____ B. WING _____	C 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF CRYSTAL LL(	3501 DOUGLAS DRIVE MINNEAPOLIS, MN 55442

(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: #HL388604783C/#HL388604122M #HL388604237C/#HL388603783M On October 4, 2024, 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 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL388604783C/#HL388604122M, tag identification 0620, and 2360.	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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report an incident of suspected abuse to the Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for one of one resident, R2, reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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 situation has occurred only occasionally). Findings include:	0 620		

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0 620	Continued From page 3 R2's diagnoses included right-sided hemiplegia, generalized muscle weakness, and aphasia. R2's service plan dated October 24, 2023, included assistance with activities of daily living, medication management, housekeeping, laundry, and meals. The resident was an assist of two staff using an EZ stand for transfers and toileting. During interview on October 4, 2024, the regional director of nursing (RN)-A stated she and other staff leaders reviewed video clips provided by R2's power of attorney (POA)-H in which two staff members, (ULP)-I and (ULP)-J, were witnessed emotionally abusing R2 during their shifts on June 7, 2024, and June 8, 2024. RN-A said facility leadership knew POA-H was going to call in a MAARC report, so the facility did not call in a report due to it being redundant. The facility's policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated July 19, 2021, indicated staff who suspect maltreatment of a resident would contact MAARC and such a report must be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02360	144G.91 Subd. 8 Freedom from maltreatment 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.	02360		

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02360	Continued From page 4 This MN Requirement is not met as evidenced by: The facility failed to ensure one of two resident reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual(s)were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		