Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390817022M
Compliance #: HL390811587C

Date Concluded: April 15, 2025

Name, Address, and County of Licensee Investigated:
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112
Ramsey County

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

Evaluator's Name: Willette Shafer, RN
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) neglected the resident when the AP failed to supervise the resident per the resident's care plan during a shower and the resident fell.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to provide stand by assistance during the resident's shower per the resident's service plan and the resident fell. The AP failed to report the incident to a nurse and failed to follow facility protocol after the resident fell. The resident complained of back pain for a few days after the fall. He was sent to the hospital and diagnosed with a spinal fracture.

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 resident records, hospital records, facility internal investigation,

facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff members assisting with resident cares.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis and frequent falls. The resident's service plan included standby assist of one staff during bathing. The resident's assessment indicated the resident had moderate cognitive impairment and was at risk for falls. The nursing assessment indicated the resident was at risk for falls and had a prior fall while at the facility resulting in an injury that caused bleeding in his brain.

The resident's service delivery record indicated the AP provide standby bathing assistance the evening of the incident.

The internal investigation indicated while the AP assisted the resident with a shower, the AP stepped away to get more towels and the resident fell. The AP's interview summary in the internal investigation indicated the resident fell when the AP stepped away to get towels. The AP reported he assisted the resident up. The AP failed to follow the proper procedure after a fall and failed to report the fall. Multiple family members were interviewed for the internal investigation, they reported the resident told them the AP stepped away while assisting him with a shower. The resident fell off the shower chair and landed on his bottom. The resident said the AP assisted him up and the family was not notified.

The resident's progress notes indicated the resident's back was "hurting very badly from his fall. " A member of management spoke with a family member who reported the resident told the family member he fell and had significant pain in his back. The family member made an appointment for the resident to be assessed by his primary care provider, but the resident refused the appointment. The following day the facility sent the resident to the hospital for continued pain and increased confusion. The resident went to a transitional care unit for two weeks following the injury.

The resident's hospital record indicated he was sent to the hospital two days after a fall while getting out of the shower. He was diagnosed with a fracture in his spine.

During an interview, a member of management said the AP reported he left the resident alone in the shower to get towels and the resident fell. He assisted the resident off the floor and failed to report the fall to anyone. The resident's family member reported the resident complained of pain and reported he fell in the shower. The resident identified the AP as the staff assisting him during the incident. The resident was sent to the hospital where he was diagnosed with a fracture in his back. He stayed at a transitional care unit for two weeks before returning to the facility.

During an interview, the nurse said the AP left the resident unattended in the bathroom while removing towels and the resident fell. The resident reported the AP received a phone call and

he left the area. The AP was trained to stay with the resident when a resident's service plan indicated stand by assist. The AP failed to report the fall to a nurse and failed to follow the protocol after a resident fell.

During an interview, a family member said the resident reported he fell in the shower. The resident was able to identify the AP who assisted him with his shower. The resident said the AP received a phone call and left the bathroom, then the resident fell. The resident complained of pain and was sent to the hospital a few days later. At the hospital, the resident was diagnosed with a spinal fracture. He was sent to a transitional care unit for a couple weeks and then returned to the facility.

During an interview, the AP said he assisted the resident with a shower. While he was removing the wet towels, he heard the shower chair move. The AP turned around and the resident was standing up. He denied witnessing the resident fall. The AP said he was unable to remember details of the incident including what he reported to management about the incident during the internal investigation.

The facility's falls policy indicated after a resident fall; the staff member must notify a nurse before moving a resident. A post fall procedure with specific steps based on evaluation must be followed after a fall to ensure the resident's health and safety.

The daily schedule indicated a second staff member was assigned to the assisted living unit on the evening of the incident and available to the AP to call for assistance.

The AP's training record indicated the AP received training on resident falls multiple times before the incident.

In conclusion, the Minnesota Department of Health determined neglect 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.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and sent the resident to the hospital.

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
Ramsey County Attorney
Arden Hills City Attorney

Arden Hills Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39081	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUND LAKE SENIOR LIVING	1740 PARKSHORE DRIVE ARDEN HILLS, MN 55112

(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: HL390811587C/HL390817022M On April 1, 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 84 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL390811587C/HL390817022M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: 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. Please refer to the public maltreatment report for details.	02360		