Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL394045602M
Compliance #: HL394043145C

Date Concluded: November 6, 2025

Name, Address, and County of Licensee Investigated:

Suite Living Senior Care of LI
525 Osborne Road NE
Spring Lake Park, MN 55432-2751
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 resident was neglected when the resident had a decline in health, passed away four days later and family was not notified.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff reported the resident's change in condition to facility nurses, hospice nurses, facility staff monitored the resident, and the hospice nurse assessed the resident. The resident's family was contacted regarding the resident's declining condition and the family requested the resident be transported to the hospital where the resident died while on comfort care.
The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's hospice nurse. The investigation included review of the resident record(s), death record, hospital records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the

investigator observed the facility's physical plant, medication administrations and staff interaction during cares.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's Disease [a progressive disease that causes confusion, memory loss and other cognitive declines]. The resident's service plan included assistance with activities of daily living such as dressing, toileting, medication management and safety checks every two hours. The resident's assessment indicated the resident received hospice services, had mild disorientation and judgement deficits.

Medical records indicated the resident's hospice massage therapist reported the resident's upper respiratory symptoms to the facility nurse, who assessed the resident and observed the resident to have a cough, chills, runny nose and low-grade fever. The facility nurse then updated the resident's provider and completed a Rapid COVID-19 test which was negative. The facility nurse also updated the hospice nurse. Later this same day, the resident had a fall that was without injury and staff reported the fall to the facility's on-call nurse. Staff monitored the resident for pain, injury and vital signs for the following two days.

Medical records indicated on the next day, the resident had increased weakness, fatigue, decreased appetite and was pale. Staff updated the on-call facility nurse and the hospice nurse, who assessed the resident the same day. Staff continued to monitor the resident every two hours and obtain the resident's vital signs.

Medical records indicated the next day, staff reported to the on-call nurse and the hospice nurse, that the resident experienced diarrhea and dizziness. Later this same day, the resident became unresponsive, had low blood pressure and had low oxygen saturation levels [measures oxygen in the blood]. Staff reported the symptoms to the hospice nurse, who contacted the resident's family. The resident's family requested to have the resident sent to the hospital for evaluation.

Hospital Medical Records indicated the resident was admitted to the hospital and placed on comfort care; the resident died four days after the onset of the symptoms.

During an interview, an on-call nurse stated staff reported the resident had a fall at the on-set of the changes in condition and staff monitored the resident for injuries and further change in condition until the resident was transported to the hospital.

During an interview, the resident's hospice nurse, stated a hospice nurse assessed the resident the day after the onset of the upper respiratory symptoms and there were no changes to the resident's goals of care on that day.

During an interview, an administrative nurse stated the resident's upper respiratory symptoms were reported by the resident's hospice nurse. The administrative nurse stated she updated

staff and the resident's hospice nurse regarding an ordered COVID-19 test that was negative as well as updated staff to monitor the resident for further symptoms, push fluids, and administer Tylenol as needed via an electric health records message system.

During an interview, the resident's family member stated that although staff did not notify of the resident's COVID-19 test results, staff and the resident's hospice nurse updated the family member regarding the resident's change in condition and fall over the four days the resident was observed to decline. The family member recalled facility staff and the resident's hospice nurse followed family request to transport the resident to the hospital after the resident's oxygen saturation levels were low.

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.
Insert maltreatment definition here.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility staff reported and assessed the resident's change in condition.
Facility staff reported incidences to facility nursing and the resident's hospice nurse.
Facility staff transported the resident to the hospital for evaluation.

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
	39404	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF SPRING LAKI	525 OSBORNE ROAD SPRING LAKE PARK, MN 55432

(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 September 30, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL394043145C/#HL394045602M. No correction orders are issued.	0 000		