

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396675202M
Compliance #: HL396677021C

Date Concluded: November 7, 2024

Name, Address, and County of Licensee

Investigated:

Grace Assisted Living
7007 Greenbriar Curve
Shakopee, MN 55379
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Julie Serbus, 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 failed to ensure the resident was free from neglect when care planned services including medication administration and personal hygiene were not consistently provided to the resident leading to multiple hospitalizations.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although, the resident of the facility, the facility was unable to complete services daily due to the resident absences.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager. The investigation included review of the resident's plan of care, assessments, progress notes, delivered services, and Individual Abuse Prevention Plan. Also, the investigator completed an onsite visit to observe how the facility staff interact with current residents.

The resident resided in an assisted living facility. The resident's diagnoses included toxic encephalopathy (syndrome of overall brain dysfunction), chronic kidney disease, diabetes, and below the knee amputation. The resident's service plan included safety checks while in the facility, transfer assistance, assistance with bathing and hygiene, and medication administration. The resident's assessment indicated resident's support group is his friends, resident can make himself understood, a history of substance use with multiple hospital stays, and the resident leaving the hospital against medical advice, and seldom returned to the facility after hospitalization.

A concern arose that the facility was not providing the resident with care plan services. The concern included the lack of medication administration and providing assistance with personal hygiene.

The signed assisted living contract between the resident and the facility indicated if the resident was not available for scheduled service, or if the resident elected to cancel or reschedule services the resident agreed to contact the facility within 24 hours of the scheduled service.

During an interview, a nurse stated shortly after admission the resident would leave the facility for undetermined periods of time. The nurse stated the resident would voluntarily leave stating he would be back shortly and did not take prescribed medications with him. The nurse stated the resident would leave the facility and eventually ended up admitted to a hospital. The nurse stated the facility would receive a call from a hospital stating resident had been admitted. However, even upon discharge from the hospital, multiple times he did not return to the facility so that if the hospital prescribed new medication orders and the facility was not consistently updated with those changes. The nurse stated the resident used an electric wheelchair for mobility.

During an interview, an unlicensed caregiver stated resident was mostly out of the facility but when he was at the facility then caregivers assisted him with hygiene, skin care, and administering medications. The caregiver stated the resident was able to verbalize he needs and use his call light independently. The caregiver stated medications were not sent with resident when he left the facility as he did not give staff the opportunity or time to pack up the medications when leaving.

During an interview, a manager stated the resident's case manager was aware the resident was often away from the facility and subsequently missed medications. The manager stated it was difficult to provide services when the resident was not at the facility and/or left without warning. The manager stated the resident did not have a contact number or address unless he is in the hospital and the hospital notifies the facility.

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, no contact information available

Family/Responsible Party interviewed: No, resident is his own guardian.

Alleged Perpetrator interviewed: NA

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: 39667	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/10/2024
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NAME OF PROVIDER OR SUPPLIER GRACE ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7007 GREENBRIAR CURVE SHAKOPEE, MN 55379
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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>Initial Comments</p> <p>On October 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396677021C/#HL396675202M. No correction orders are issued.</p> <p>Additionally, on October 10, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396676648C/#HL396675061M. No correction orders are issued.</p>	0 000		

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