Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL406737922M
Compliance #: HL406733880C

Date Concluded: April 7

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Maple Grove
7010 Alvarado Lane North
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive

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 when the resident complained of leg pain and was diagnosed at the hospital with a urinary tract infection (UTI), and ankle, knee, and hip fractures. Facility staff did not know how the resident sustained the fractures.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident fell in her apartment, and for a week after her fall, the resident did not complain of increased pain, nor were there visible signs of injury. One week after falling, the resident complained of left leg pain. The resident was sent to the hospital for further evaluation, where she was admitted and diagnosed with an ankle fracture. Although facility staff were not sure how the fracture occurred, hospital documentation attributed the ankle fracture to the resident's fall and osteopenia.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family and an outside caregiver. The investigation included review of the resident record, hospital records, the facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included osteopenia, lumbar vertebral disc degeneration, back pain. The resident's services included safety checks, socialization, assistance with medication management, meals, activities of daily living, and housekeeping. The resident's assessment indicated the resident required chronic pain management.

Review of the internal investigation indicated one night the resident fell and hit her head. A facility nurse assessed the resident and found no significant pain or injury. The nurse determined the resident's cares should increase from assist of one to assist of two for ambulation and transfers, with a standing lift. Two days later, the family installed a camera in the resident's room. Four days later, after reviewing camera footage, a family member entered the facility and told staff the resident was falling out of her chair. She reported the resident was yelling out for help and staff were sitting at the desk. Staff had trouble positioning the resident in her recliner, as she would frequently slide down and decline help. Facility leadership reviewed the pendant report, and the resident had not pressed her pendant for help. Staff reported they checked on the resident several times on the overnight shift to ensure she wasn't sliding out of her chair.

Seven days after the fall, the resident complained of leg pain and was sent to the hospital. The daughter reported to the facility that multiple fractures were discovered. According to staff and family, complaints of pain started early in the morning, around 2:00 a.m. or 3:00 a.m. The family member said staff told the resident they would not call 911 for her. Review of facility cameras for that overnight shift revealed evening and overnight staff entering resident's apartment four times, after which time a call was placed to the on-call nurse.
Facility leadership interviewed staff to determine if the resident had fallen again, but she had not.

The internal investigation indicated upon interview an overnight staff member said he and a coworker peeked on the resident a few times and around 3:00 a.m. they both helped get her leg back into bed, as it was hanging off side of bed. The resident would not let them help, however, and threatened to call the police. The staff member said at no point did they say they would not call 911 for her pain. The staff member said although the resident slid down in her recliner a lot, requiring frequent adjustment, she experienced no further falls.

The internal investigation summarized no unreported falls prior to the hospitalization, and no reported complaints of pain until the morning the resident went to the hospital. A facility nurse

suspected the resident's fractures might be related to osteoporosis and constant pushing with her legs off the floor after sliding down in her recliner.

Review of incident reports indicated the resident fell three times over the course of three months. The final fall occurred when the resident walked toward her microwave and lost her balance. The resident said she fell backward onto floor and hit her head. Staff helped the resident off the floor with a mechanical lift. The resident denied pain and a facility nurse noted no injuries.

Review of the resident's progress notes indicated the resident summoned staff with her pendant after she fell in her apartment. The resident said she lost balance and fell backward, hitting the back of her head. A facility nurse found no notable signs of injury. The resident denied pain or discomfort. Per the resident's medication administration record (MAR), she received 2 tablets of Tylenol 500mg three times a day for chronic pain. A week later, overnight staff called the on-call nurse to report the resident complained of leg pain and requested staff call 911. A family member verbalized displeasure about the resident having to call 911 herself, but it was unable to be determined from the progress notes if it was the resident or staff who called 911.

Review of the nursing assessment completed after the resident fell indicated the nurse ordered a new intervention: The resident was an assist of two using a standing lift to wheelchair. Staff were to ensure the resident's wheelchair was always within reach. The resident had a weak gain, and cognitively the resident was not always oriented, but she was able to use the call system.

Review of the resident's hospital record indicated she was diagnosed with a left malleolus (ankle) fracture secondary to a fall and osteopenia. The resident reported ongoing pain in her left leg since she fell and had difficulty walking with her walker. The resident said she had so much pain that she screamed and was unable to lift her leg. Hospital staff document the resident was a poor historian and might have had mild to moderate cognitive impairment. The ankle fracture was minimally displaced, and an orthopedic consult indicated no surgical intervention was required, conservative management was recommended. Physical therapy/occupational therapy (PT/OT) consults were ordered, and the resident could ambulate (walk) as tolerated. Computed tomography (CT) scans indicated the resident had no head injuries or intracranial bleeds. Neurology determined the resident was able to move all her extremities. The resident had an indwelling foley catheter that had been changed 11 days prior by her external provider. Her urinalysis was positive for bacterial colonization. The resident was discharged to a higher level of care after one week.

When interviewed, a facility administrator said staff and family noted a steady decline in the resident's cognition and discussed odd statements the resident had made, Family decided to place a camera in the resident's room. Staff had a difficult time keeping the resident placed appropriately in her recliner. Sliding down in the recliner caused irritation with the resident, but

she did not report significant pain until the morning of her hospitalization. After learning about the fractures, staff were interviewed, and no unreported falls were verified. The administrator stated the fractures might have been related to the constant sliding down in her recliner and then pulling herself back up, aggravated by osteoporosis. The family felt staff were not listening to requests to check in on the resident and, per pendant reporter, the resident was not using her pendant to call for help. However, staff reported they frequently checked on the resident to ensure proper placement in her recliner.

When interviewed, a facility nurse said the resident was ambulatory at the time of the fall, with a four-wheeled walker. Toward the end of the resident's stay, there was an increase in her confusion. The resident spent a lot of time in her recliner, and she would frequently slide down while seated in it. Review of camera footage (cameras were placed in the facility's hallways) revealed staff were in the resident's room frequently on overnights, and no further falls were reported. The resident was still able to bear weight for transfers and there were no complaints of increased pain. The morning the resident was hospitalized, camera footage showed staff going in numerous times to do checks and at no time did the resident say she was in pain.

When interviewed, an external provider said the resident was sliding out of her recliner and told her she had been that way for days, as staff would not get her up. The external provider said the resident was confused but could tell she was uncomfortable. The resident said staff only got her up when she needed to use the bathroom. The external provider tried to find a staff member to help reposition the resident but was told they did not have orders to use a lift for the resident, or the right equipment, or the right staff. A family member told the external provider the resident had been in the chair for 48 hours and had not moved. The family member said staff would not help the resident until the family member brought the resident a new recliner that worked better. The external provider said the resident complained of back pain, but not pain in her legs.

When interviewed, a family member said they had put a camera in the resident's room two days before she left for the hospital. The family member said when she reviewed camera footage, the resident was in the same position and the same clothes. At one point, the family member went to the facility to tell them to reposition the resident and staff said the resident would just "end up like that again." The next morning, the family member saw the resident was falling out of bed, so she called the facility. The family member returned to the facility and had to insist staff use a gait belt to reposition the resident. The family member said the resident would frequently holler for help and staff would not respond. Facility leadership told the family member staff were in the resident's room frequently, and the family member wanted to know what they did in there. The family member said after the fall the resident was not able to walk or move anymore, and no one notified family. The day the resident was hospitalized, the family member said staff made the resident call 911 herself and would not help her with that. At the hospital, the resident was diagnosed with a broken ankle bone.

When interviewed the resident did not recall details surrounding her time at the facility and her hospitalization.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an internal investigation. The facility re-educated staff regarding the use of gait belts and lifts.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

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
	40673	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF MAPLE GROV	7010 ALVARADO LANE MAPLE GROVE, MN 55311

(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: #HL406733880C/#HL406737922M On February 25, 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 28 residents receiving services under the provider's Provisional Assisted Living with Dementia Care license. The following correction order is issued for #HL406733880C/#HL406737922M, tag identification 0450.	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.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide services in a person-centered manner for one of one resident reviewed (R1). R1 continually slid down in her recliner and was not able to reposition herself without staff assistance. Lying in the recliner in an uncomfortable position for long periods of time increased the residents chronic pain. 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). The findings include: R1's diagnoses included osteopenia, degeneration of lumbar vertebral disc, and back pain.	0 450		

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0 450	Continued From page 2 R1's service plan dated July 29, 2024, indicated R1 received assistance with dressing, grooming, bathing, transfers, mobility, and medication administration. R1 required the assistance of two staff members using a standing lift with use of gait belt and wheelchair for mobility. An internal investigation document, dated December 24, 2024, indicated staff stated R1 became aggressive when they tried to help reposition her in her recliner. Staff said they would frequently attempt to help R1 reposition in her recliner, but she would slide down again. Several times R1 slid down far enough to nearly fall out of her recliner, but she never fell to the floor. An undated photograph of R1 provided by a family member (Fam)-B showed the resident lying flat in her recliner. Her torso was on the seat of the recliner, her buttocks and thighs were on the extended footrest, and her legs were bent at the knee with her feet on the floor. R1's arms were squeezed to her sides by the right and left arm rests of the recliner. R1 appeared to be grimacing. On February 25, 2025, at 12:30 p.m., a facility administrator (Admin)-A stated staff had a difficult time keeping R1 placed appropriately in her recliner. Admin-A said sliding down in her recliner caused irritation with R1, but she did not report significant pain until the day of her hospitalization on December 24, 2024. On March 4 ,2025, at 9:25 a.m., Fam-B said a camera was placed in R1's room two days before she was hospitalized. Fam-B noticed one morning R1 was in the same clothes as the day	0 450		

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0 450	Continued From page 3 before, she had not been changed for bed, and she was still in her recliner, almost falling off it. Fam-B drove to the facility to encourage staff to help reposition R1. Fam-B said staff told her "she'll just be like this again." The second day, Fam-B said she heard R1 hollering for help with no staff assistance. Fam-B drove to the facility and said staff attempted to reposition R1 by "yanking" under her arms rather than using a gait belt. Fam-B said staff continued to decline to use the gait belt until Fam-B wrapped the belt around R1. The facility's Bill of Rights policy, dated July 19, 2021, indicated staff would be trained on the rights contained in the Bill of Rights. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		