*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL213878847M
**Compliance #:** HL213876452C

**Date Concluded:** April 22, 2024

**Name, Address, and County of Licensee Investigated:**
Rose Arbor Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311
Hennepin County

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

**Evaluator's Name:** Lissa Lin, 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 she failed to conduct scheduled safety checks on the resident, slept during her shift and failed to answer the resident's call pendant. The resident was short of breath and called 911 for help.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP slept during her night shift and failed to conduct two-hour safety checks on the resident as directed in her service plan, failed to answer the resident's call pendant when she needed help, and failed to answer the resident's call pendant when activated by EMS staff, who could not find the AP. The resident was short of breath for a couple of hours and was unable to reach her oxygen nasal cannula.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The investigator reviewed the law enforcement report and ambulance report. Also, the investigator observed overnight staff in the memory care unit cleaning common areas and checking residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included chronic obstructive pulmonary disease (COPD), stroke, and respiratory failure. The resident's service plan included scheduled safety checks every two hours. The resident had a physician's order for oxygen, two liters per minute as needed. The resident received hospice care. The resident's assessments indicated she had occasional disorientation to person, place, time, or situation. She was vulnerable to self-abuse due to inability to provide self-care. The resident required staff to assist with all cares and report any concerns to the nurse.

The law enforcement report and ambulance reports indicated around 4:00 a.m., the resident called 911 for help because she was short of breath. When law enforcement and paramedics arrived, they found the resident in her room short of breath. Her oxygen tubing was on the floor with the oxygen running. The resident said her shortness of breath started a few hours earlier. She used her call pendant to summon staff for help, but no one came. One of the paramedics activated the resident's call pendant, however no staff arrived. The law enforcement officer and another paramedic went looking for the AP and found her asleep on a couch. When they woke the AP, she said she had not been asleep. She did not know the resident had called 911 or used her call pendant for help. The paramedic asked the AP about the resident's cares and medications, but the AP struggled to find information on the laptop. The AP handed it to the paramedic who observed a big red box on the screen indicating the AP had missed a scheduled safety check on the resident. The AP stated she last checked the resident about three hours earlier. The AP provided the resident with an as needed nebulizer treatment and increased her oxygen. The resident said she felt better and declined going to the hospital. One of the paramedics called the resident's family member and a facility manager about the incident.

Review of the alarm activation report indicated the resident's call alarm had two alarms the night of the incident [the resident activation, the paramedic staff activation].

During an interview, the AP said she did not sleep during her overnight shift. The AP said when the law enforcement officer and the paramedic found her in the common area, she was watching a newer resident who would not go to sleep. She was awake all night and did her two-hour checks on the resident. The AP stated she had no idea the resident had called 911 and did not get a call pendant alert.

During an interview with a manager, he said he found out about the incident days later. First responders had a hard time getting into the building and finding the AP. The manager said there were reports of a few staff members sleeping during work and the AP was one of them. The manager said staff can only sleep on their break in the breakroom and that was part of their training. There was no video available to review.

During an interview, a former staff nurse said he spoke to the AP once about sleeping during her shift but did not recall if he documented the meeting.

During an interview, the family member said she was not sure staff members always did two-hour safety checks on the resident. She said the resident could get confused and remove her oxygen tubing and if staff were checking on her regularly, they would have caught that.

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.

**Vulnerable Adult interviewed**: No, deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
No action taken by the facility related to the incident. The AP was no longer employed at facility for an unrelated concern.

**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

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
Hennepin County Attorney
Maple Grove City Attorney
Maple Grove Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21387 | A. BUILDING: _____ B. WING _____ | C 03/19/2024 |

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| ROSE ARBOR/WILDFLOWER LODGE | 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL213876452C/#HL213878847M<br><br>On March 19, 20024, 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 60 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction orders are issued for #HL213876452C/#HL213878847M, tag identification 0470 and 2360. | 0 000 | 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 Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that: | 0 470 | | |

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| 0 470 | Continued From page 1<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff remained awake during the overnight shift. Unlicensed personnel (ULP)-K was asleep when police and paramedics arrived to answer a 911 call for one of one residents (R1). This deficient practice affected all residents.<br><br>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 | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1's medical diagnoses included chronic obstructive pulmonary disease (COPD), respiratory failure and cerebral infarction. R1's Individual Abuse Prevention Plan dated May 25, 2023, indicated R1 was susceptible to self-abuse in the area of inability to care for self-help needs. Staff were to assist R1 with all cares and notify nurse with any concerns.<br><br>R1's service plan detail dated May 26, 2023, indicated under the emergency response section, R1 received safety checks: during waking hours three times per day. The service plan detail however, indicated in the dressing/activities of daily living section R1 received safety checks every two hours as scheduled.<br><br>R1 had a physician's order for oxygen, 2 liters per minute as needed.<br><br>R1's service delivery record dated September 2023, included wellness checks scheduled every two hours, starting at 12:00 a.m. On September 25, 2023, ULP-K documented she completed checks at 12:00 a.m., 2:00 a.m., 4:00 a.m. and 6:00 a.m. There was no information on when ULP-K made the electronic entries.<br><br>Review of a record titled Alarms By Apartment By Weekday, dated September 24, 2023, 12:00 a.m. to October 4, 2023, 11:59 p.m., indicated room | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>R1's room had two alarms on Monday, September 25, 2023. The record did not include the time of the alarm or for how long the alarm was activated.<br><br>A law enforcement report dated September 25, 2023, at 4:19 a.m., indicated law enforcement officer (LE)-J and emergency medical services (EMS) were dispatched to a 'difficulty breathing' call at the licensee in the memory care unit. They located R1 in her room. R1 had an oxygen tank in her room and a nasal cannula she was not wearing. R1 had difficulty breathing. LE-J indicated R1 pulled the emergency alert cord but no staff came to help her so she called 911. LE-J went to look for memory care staff. She walked to a common area where she saw a resident seated in a wheelchair and someone asleep on a couch. The sleeping person was identified as ULP-K. She was in charge of caring for residents on the second floor that shift. LE-J indicated she woke ULP-K, who told LE-J she was not sleeping. LE-J's report indicated ULP-K was not able to access R1's medical information on her computer and could not verbalize R1's medications. LE-J indicated UP-K's computer screen showed a large red box that indicated ULP-K missed a routine check on R1, R1 needed checks every two hours and the last check was completed at 1:00 a.m. LE-J's report indicated another officer had a similar situation with ULP-K weeks earlier. There was no report on that incident.<br><br>An EMS "Pre-Hospital Care Report" dated September 25, 2023, at 4:20 p.m. indicated the primary impression was respiratory, shortness of breath. EMS staff found R1 seated in a chair in her room. She told EMS staff her difficulty breathing began a few hours earlier before she called 911. R1's nasal cannula was on the floor, | 0 470 | | |

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| 0 470 | Continued From page 4<br><br>her oxygen running at one liter. She had increased respiratory effort, wheezes in the lower lobes and her spO2 (oximeter reading) was at 90%. The EMS staff activated the resident's call light, which went unanswered. EMS and LE-J eventually found ULP-K asleep on a couch. R1 declined going to the hospital. She received a medication for her breathing. Family member (FM)-I was contacted about the incident and one of the EMS staff called facility management to report the incident with R1.<br><br>R1's progress note dated September 25, 2023, at 3:18 p.m., indicated registered nurse (RN)-L received a call around 5:00 a.m. R1 called 911 due to shortness of breath. R1 was not wearing her oxygen, EMS placed cannula (tubing) in her nose. RN-L arrived at 8:00 a.m. and R1 stated she felt better.<br><br>During an interview on March 28, 2024, at 1:00 p.m., ULP-K said she never slept during her shifts, it was not allowed and she could get fired. The night police and paramedics arrived, she was watching a resident who would not go to sleep. They were seated in the commons area of the memory care unit on second floor. The lights were off, but ULP-K said she was awake. ULP-K said the paramedic was frustrated at her because she had to walk far to reach the memory care building. ULP-K said she had no idea R1 had called 911 and told the paramedic she did not get a call pendant alert from R1. ULP-K said R1 was not compliant with her oxygen and often removed the tubing from her nose.<br><br>During an interview on March 29, 2024, at 9:30 a.m., FM-I said R1 had hospice services and lived at the licensee about six months before she died. FM-I said she was not sure staff did the | 0 470 | | |

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| 0 470 | Continued From page 5<br><br>scheduled two hour checks on R1. FM-I said R1 could get confused and remove her oxygen tubing. If staff checked on her regularly they would have caught that.<br><br>During an interview on March 29, 2024, at 10:24 a.m., RN-L said there were reports of staff sleeping during overnight shifts and ULP-K was one of those staff members. RN-L said he spoke to her once about not sleeping on her shift, but did not recall if there was documentation. RN-L said no staff members could sleep during work.<br><br>A policy titled ALDC [Assisted Living Dementia Care] Physical Environment, Fire Protecting and Staff, revised February 28, 2024, indicated an awake staff person will be physically present within the secured unit at all times.<br><br>TIME PERIOD TO CORRECT: Seven (7) Days | 0 470 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>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 | 02360 | No plan of correction is required for this tag. | |

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| 02360 | Continued From page 6<br>occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |