Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL257291621M
Compliance #: HL257299134C

Date Concluded: July 15, 2024

Name, Address, and County of Licensee Investigated:
Select Senior Living
11350 Martin Street NW
Coon Rapids, MN. 55433
Anoka County

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

Evaluator's Name:
Katherine Barnhardt 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 neglected the resident when the facility failed to assess and intervene when the resident had a significant change of condition. In addition, the resident fell because staff failed to use a sling for transfers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided care according to the resident's plan of care and facility policies and procedures. Facility staff updated the nurse when the resident refused breakfast and did not want to get up for the day. In the time frame of the allegation of a fall, there was no evidence the resident fell or fell from a sling.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, family members, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, facility incident reports, personnel files, staff

schedules, physician notes, and related facility policies and procedures. Also, the investigator toured the facility and observed interactions between facility staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, dysphagia (difficulty swallowing), and chronic kidney disease. The resident's service plan included assistance with medication administration, meal delivery, hydration assistance, escorts, and safety checks. The resident required assistance with transfers and ambulated with assist of one and a four-wheeled walker. The resident was independent with toileting at the request of the family and resident. The resident was orientated to person, place and time, able to communicate and make needs known, however, had slurred speech that could impact communication with others and would have periods of forgetfulness. The resident had a call pendant to call staff for assistance.

Facility documentation indicated facility staff had informed family members and the nurse earlier one day that the resident requested to stay in bed due to being tired from the previous day, declined breakfast, had not drank much and ate soup for a late lunch. The resident's family arrived in the evening for a visit and family arranged for the resident to be evaluated at a hospital.

The resident's hospital record indicated during the resident's initial evaluation, the resident was alert, communicated with hospital staff and the resident's vital signs were within acceptable range. The admitting emergency room physician noted "no acute distress, urine positive for infection, does not appear septic". During the hospital stay, the resident was diagnosed with aspiration pneumonia (a type of lung infection caused by a relatively large amount of material from the stomach or mouth entering the lungs.) The hospital planned to discharge the resident on the third hospital day however, the resident had a rapid decline in health and passed away at the hospital.

The resident's death record indicated the resident's primary cause of death was aspiration pneumonia.

During an interview, the nurse stated staff had updated her in the morning on the day family had arranged for the resident to be evaluated at a hospital. The nurse stated staff had notified her the resident had not eaten breakfast and did not want to get up for the day, however, it was not unusual for the resident to refuse breakfast. The nurse stated the resident had eaten soup for a late lunch and the resident told staff she was tired from holiday activities and gatherings the previous day. The nurse stated family members had sent pictures of themselves with the resident during the holiday gathering the prior evening and the resident appeared to be "smiling and doing well". The nurse stated the resident's room included video and audio surveillance that allowed the resident and family to communicate 24 hours a day, seven days a week. The resident did not convey any health concerns to the family by the video link that day, even though it was used often by the resident and the family. The nurse stated family arrived at

the facility in the evening and arranged for the resident to be evaluated at a hospital without notifying any staff or the nurse of concerns or sudden changes in the resident.

During an interview, a family member stated the resident had called them the day after the family gathering and told them she did not feel well, and she seemed tired. The family member went to the facility that evening to check on the resident, and because the resident failed to recognize the family, they arranged for the resident to be evaluated at a hospital.

Another concern investigated included later in the fall the previous year, it was alleged the resident fell during a transfer when staff failed to use a sling lift. At the time of the alleged fall, the resident did not transfer with a sling and the record contained no evidence of a fall.

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” 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: Not Applicable

Action taken by facility:
The facility reviewed their protocols and procedures.

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
	25729	A. BUILDING: _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SENIOR LIVING OF COON RAPIDS LLC	11350 MARTIN STREET NW COON RAPIDS, MN 55433

(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 June 5, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL257291621M/#HL257299134C. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	