Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286053025M
Compliance #: HL286054947C

Date Concluded: September 18, 2023

Name, Address, and County of Licensee Investigated:
Summit Hill Senior Living
1824 Old Hudson Rd
Saint Paul, MN 55119
Ramsey County

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

Evaluator's Name: Yolanda Dawson, 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 alleged perpetrator (AP), facility staff, neglected a resident when the AP allowed the resident to refuse medical treatment when he presented with signs and symptoms of infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the incident, the resident was being monitored by urology (works with diseases of the urinary tract), his primary provider, facility nursing staff, and contracted agency skilled nursing. The residents experienced a sudden decline in health.

The investigator conducted interviews with facility staff members, including, administrative staff, nursing staff, and unlicensed staff. The investigator contacted the skilled nursing agency providing physical therapy and wound care. The investigation included review of resident records, employee records, staff documentation, and agency documentation.

The resident resided in an assisted living facility. The resident's diagnoses included rheumatoid arthritis, lower extremity lymphedema (swelling), chronic pain lower legs, and chronic kidney disease. The resident made his own decisions. The resident's service plan included assistance with medication management, dressing and grooming as needed, standby assist with showering as needed. The resident was independent with activities of daily living and was mobile with a walker and electronic wheelchair. The resident's assessment indicated the resident had a history of a rapid decline in health becoming disoriented, confused, and resistive to care.

A contracted occupational therapist (OT) visit note indicated one day the resident presented with signs and symptoms of infection. The resident's left lower leg was bright red, shiny and warm to touch. The resident had an elevated temperature and was visibly shaking. The resident was soiled and refused to be cleaned up. The OT advised the resident he needed an evaluation in an emergency department however, the resident refused stating he wanted to wait until the next day. The OT informed the resident it was not safe for him to be left in his present condition and called 911.

A contracted skilled nursing note indicated in the months leading up to the resident's hospitalization he was being treated and monitored by the urology clinic, his primary provider, and a contracted skilled nursing agency. A nurse documented the week before the resident became ill, his ankles were red but not hot to touch.

Nursing progress notes indicated the month before his hospitalization, the resident removed his urinary catheter and refused to have another one placed. The resident was seen at the facility by a nurse practitioner the day before he was hospitalized for complaints of right hip pain. At that time, the nurse practitioner recommended the resident be evaluated at a hospital, however the resident declined. The day of his hospitalization, urology was trying to contact the resident and he was not returning the calls. The facility nurse followed up with the resident to contact urology, but the resident stated he would do it later.

The progress note indicated the resident required hospitalization for sepsis (blood infection) possibly due to a urinary tract infection and returned to the facility 10 days later.

During an interview, the OT stated the resident made decisions for himself, however, he did not take good care of himself and often refused physical therapy or services by the nurse. The OT stated on the day of his decline the resident refused to go to the hospital. The OT stated she told the resident he could refuse to go with the paramedics, however, 911 was being called.

During an interview, the facility nurse stated she completed a dressing change to the resident's left ankle the day before he was hospitalized, and it was not hot to the touch, and the resident did not appear to be sick. The nurse stated the home health aides did not report the resident was sick or not feeling well.

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, attempted but did not reach.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The residents care plan was reviewed.

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
	28605	A. BUILDING: _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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 July 6, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL286053223M/#HL286055258C/#HL286053025M/#HL286054947C. No correction orders are issued.	0 000		