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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL286053602M
**Compliance #:** HL286054042C

**Date Concluded:** September 30, 2024

**Name, Address, and County of Licensee Investigated:**
Summit Hill Senior Living
1824 Old Hudson Road
St. Paul, MN 55119
Ramsey County

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

**Evaluator's Name:**
Maerin Renee, 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 the AP failed to provide safety checks and cares to the resident. Staff found the resident deceased in the morning.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP did not complete safety checks or other cares for the resident on the overnight shift.  Incoming day staff found the resident deceased in her room the following morning; approximately 10 hours since the resident was last seen by staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident records, death record, medication records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included end-stage kidney disease and diabetes. The resident's services included help with activities of daily living (such as bathing, toileting, grooming, etc.), meals, laundry, housekeeping, and medication management. The resident's assessment indicated the resident received kidney dialysis three times a week.

The resident's service plan indicated staff were to complete safety checks on the overnight (NOC) shift at 12:00 a.m., 2:00 a.m., and 4:00 a.m. The residents first safety check for the day shift was scheduled at 7:00 a.m. The service plan indicated the resident was a full code (full code signifies that every possible measure that can be used to save an individual's life should be used, whether that is cardiopulmonary resuscitation (CPR) or any other kind of intervention deemed necessary).

The facility's internal investigation indicated the evening before her death, staff reported the resident was at baseline and they observed no unusual changes. The resident took her evening medications and staff observed the resident talking to family on the phone at 8:00 p.m. Staff conducted a safety check at 10:00 p.m. and described the resident as, "up and well." The resident was in her bathroom getting ready for bed. The resident told staff she did not need anything. The resident was scheduled for three safety checks on the NOC shift, but none of them were completed. The AP stated she did not log into the point of care (POC) documentation system because she thought the electronic medication administration record (eMAR) and service tasks showed up on the same platform. The AP stated she did not complete safety checks or any cares overnight for the resident.

The investigation indicated at approximately 7:58 a.m. the following morning, day shift staff completed a safety check and found the resident sitting in her wheelchair. The staff member called the resident's name, but she did not respond. Staff called 911, and emergency medical service personnel (EMS) pronounced the resident deceased.

The resident's service record indicated a final safety check at 10:00 p.m., and staff documented the resident was "safe and okay in her room in the bathroom getting ready for bed." The resident's progress notes indicated staff discovered the resident unresponsive in her room, sitting in her chair. Staff called EMS, and EMS confirmed the resident had died.

The medical examiner report indicated the resident's cause of death was natural, related to end-stage renal (kidney) disease.

When interviewed, a supervisor stated during her internal investigation, she discovered the AP did not complete safety checks or cares for the resident on the night shift. The AP said she believed services and medications were all located on the eMAR, so she did not see that the resident needed three safety checks over the course of her shift and did not complete them.

The supervisor said the AP had been trained on both the eMAR and the point of care documentation system, so it was expected she would have known the difference.

The AP did not respond to interview requests.

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**: No, family were informed of the investigation but did not request to be interviewed.
**Alleged Perpetrator interviewed**: No, did not respond to subpoena.

**Action taken by facility:**
The facility completed an internal investigation and provided re-training for staff regarding the difference between the eMAR and service tasks.

**Action taken by the Minnesota Department of Health:**
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

| 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 08/07/2024 |

| 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<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>#HL286054042C/#HL286053602M<br><br>On August 7, 2024, 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 92 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued/orders are issued for #HL286054042C/#HL286053602M, tag identification 2360. | 0 000 | | |
| 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. | 02360 | | |

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| 02360 | Continued From page 1<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 occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |