

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL286057225M  
**Compliance #:** HL286053788C

**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:** 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), unknown facility staff, neglected a resident when the resident fell during a transfer and fractured the right tibia (lower leg bone.)

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the resident's care plan which directed staff to use two staff for a transfer. Instead, the AP transferred the resident alone and as a result, the resident fell during the transfer to the wheelchair and fractured her right leg.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of resident records, AP training records, assessment, and training policies, and staffing schedules.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes, osteoporosis, spinal stenosis, anxiety disorder, and chronic pain syndrome. The resident's assessment indicated the resident required assistance from two staff for dressing, grooming, toileting, showering, and transfers. The resident had chronic left hip and lower back pain and had a surgically implanted transcutaneous electrical nerve stimulation (TENS) unit (used to control pain.)

During interviews, several staff members stated the resident was weak and working with physical therapy to get stronger. Staff members stated they were unable to transfer the resident alone and the care plan directed staff to assist the resident with two staff.

During an interview, the AP stated she informed the resident it was her shower day and the resident stated she was too weak to get into the shower and to come back in an hour. When the AP returned, she attempted to assist the resident out of bed to the wheelchair. The resident sat up on the edge of the bed and stood up. The AP told the resident to hold on to her shoulder, however, the resident did not do this. The resident fell to the floor and twisted her right knee. The AP stated she had gotten the resident up on more than one occasion on her own and thought she could do it again. The AP stated she was aware the service plan indicated the resident was a two person assist with transfers and did not follow the service plan.

During an interview, the registered nurse (RN) stated the facility was in the process of arranging for the resident to move to a transitional care unit for physical therapy due to the resident's fluctuating abilities to assist staff with transfers. According to physical therapy, the resident transferred with the assist of one staff however, unlicensed staff reported the resident required two staff for the resident's safety. The RN stated the resident assessment and care plan directed staff to use two staff for the resident's transfers.

Nursing progress notes indicated the hospital report indicated the resident fractured her right leg and required surgery.

During an interview, the resident stated she had gotten up with the assist of one with the AP and one other staff member in the past, but on this day the resident was not strong enough. The resident stated when she stood up, she told the AP she was too weak, but it was too late, and she fell. The resident stated all other times she was transferred with the assist of two staff members.

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:** Yes.

**Family/Responsible Party interviewed:** No, resident in charge of care.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility completed an internal investigation. The AP was interviewed and educated. Staff education was provided at stand-up meetings.

**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

Saint Paul Attorney

Saint Paul Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>28605</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/24/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUMMIT HILL SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1824 OLD HUDSON ROAD</b> <b>SAINT PAUL, MN 55119</b>
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p><b>#HL286053788C/#HL286057225M</b></p> <p>On July 24, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 96 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for <b>#HL286053788C/#HL286057225M</b>, tag identification 2360.</p>	0 000		
02360	<p><b>144G.91 Subd. 8 Freedom from maltreatment</b></p> <p>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.</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		