Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL288961620M
Compliance #: HL288969133C

Date Concluded: July 30, 2024

Name, Address, and County of Licensee Investigated:
Sugar Loaf Senior Living
765 Menard Road
Winona, MN 55987
Winona County

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

Evaluator's Name: Michele Larson, 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), facility licensed staff, neglected the resident when the AP failed to assess the resident's change in condition after staff expressed concerns about the resident's cognitive and physical status following two falls in one morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to assess the resident when staff expressed concerns about the resident's deteriorating condition. When the AP refused, facility staff asked an administrative staff person (not a nurse) to check on the resident. Approximately seven hours after developing a change in condition, the facility staff arranged for the resident to be evaluated at a hospital transported in a family member's personal vehicle. The resident was diagnosed with a severe hemorrhagic stroke (brain bleed). The resident died a few weeks later due to complications from her stroke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's family member. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares during the onsite investigation.

The resident resided in a memory care unit in an assisted living facility with dementia care. The resident's diagnoses included Alzheimer's disease. The resident's service plan included safety checks. The resident's assessment indicated she had no falls in the previous four months and enjoyed dancing and walking. The resident walked independently and used no assistive devices.

A progress note indicated early one morning, a video camera in the resident's apartment alerted facility staff the resident fell. The AP responded and found the resident on the floor wearing only a top and sock. The resident appeared agitated and refused assistance off the floor. About two hours later, the resident fell again. The resident was unusually agitated and made rambling comments.

Review of the resident's video footage after her second fall indicated the resident's left leg appeared stiff and left arm hung at the resident's side as she attempted to walk dragging the left leg. The AP obtained only the resident's pulse due to the resident's agitation. The resident was seated and leaned towards her left side as the AP stood next to her. The video footage indicated for hours the resident's condition significantly declined, yet the AP failed to assess the resident.

Another progress note indicated one and one-half hours after the resident's second fall, staff reported to an administrative staff person the resident displayed abnormal behaviors of aggression, hallucinations, leg pain, and an inability to feed herself. Although the administrative staff person was not a nurse, she checked on the resident after staff told her the AP refused to do so.

The facility's internal investigation included review of the resident's video footage along with multiple staff interviews. Following a second fall, the resident's left arm and leg appeared stiff. About one and one-half hours later and due to the resident's increased confusion and inability to transfer independently, an unlicensed staff member assisted the resident to the dining room to "keep an eye on her." One hour later, the resident was leaning heavily towards her left side while seated. After another one-half hour, the resident was unable to feed herself. The resident told staff she could not see the television even when staff told the resident the television was just to the resident's left side. The AP contacted the resident's family member, indicating the resident's symptoms were "probably" due to a urinary tract infection even though the AP failed to assess the resident. Ten minutes later, staff placed an ice pack on the resident's neck after the resident complained of a stiff neck. The resident's speech and confusion worsened. The resident leaned toward the left side, slouched, with loss of vision in her left eye. An

administrative staff person contacted the resident's family member offering to call a non-emergent ambulance to transport the resident to the hospital if the family member was unable to drive the resident in her personal vehicle. The resident's family member indicated she would drive the resident to the hospital. The AP continued to insist the resident had a urinary tract infection and refused to leave the nurse's station to assess the resident even after the administrative staff person informed the AP of the resident's symptoms. Approximately seven hours after the first fall, the resident's family member arrived at the facility. The resident required full assistance from the resident's family member and two unlicensed personnel to transfer the resident into the family member's vehicle due to the resident's inability to walk and stand.

The facility's internal investigation also indicated multiple staff reported the AP appeared flustered and stressed during the shift, stating the AP stated many times she "had it for the day," and told staff to stop calling her as she was too busy. Staff indicated they stopped going to the AP with their questions or concerns about the resident due to the way the AP acted and felt the AP would not respond anyway. During the investigation, the AP stated she failed to assess the resident and instead, asked the unlicensed administrative staff person to check on the resident. The administrative staff person indicated she checked on the resident after staff requested help.

A facility progress note indicated the facility received a call from an emergency room nurse stating the resident required a higher level of care than what the hospital could provide. The emergency room nurse stated the resident should have been transported by an ambulance not a personal vehicle because the resident required immediate attention.

The resident's hospital record indicated the resident was diagnosed with a large hemorrhagic stroke (brain bleed). The resident discharged from the hospital to the facility four days later with hospice services.

The resident's certificate of death indicated the resident's primary cause of death was non-traumatic intracranial hemorrhage (brain bleed).

During an interview, the facility nurse stated the resident was physically active and walked independently prior to her stroke. The facility nurse stated the AP admitted she failed to assess the resident and stated the AP asked the unlicensed administrative staff person to check on the resident. The facility nurse stated the AP did not admit to any wrongdoing.

During an interview, the unlicensed administrative staff person stated staff members asked the AP to assess the resident but said the AP told them to stop calling her since she was too busy.

During an interview, unlicensed personnel stated the resident was always "super" happy and constantly walked and danced. The unlicensed personnel stated she found it "very" out of place when the resident fell twice and was unable to get herself off the floor stating the resident

often would get down on her hands and knees to retrieve dropped items on the floor. The unlicensed personnel stated she thought the resident looked “off,” and stated both she and another unlicensed personnel thought the resident had a stroke stating, “you know the signs of a stroke. I was happy she was going to the hospital.”

During an interview, the other unlicensed personnel stated she was frustrated when the AP “blew her off,” when she asked the AP to assess the resident. The unlicensed personnel stated the AP told her she did not have time to deal with the resident’s situation. The unlicensed personnel stated she asked the unlicensed administrative staff person to call the resident’s family so they could take the resident to a hospital to be evaluated stating the unlicensed personnel felt it was an emergent situation.

During an interview, the resident’s family member stated the AP called and left a voice message three hours after the resident’s second fall indicating it was not an emergency but call back when time permitted. The resident’s family member stated shortly after, she received a call from an unlicensed administrative staff person stating the resident was unable to feed herself, had increased confusion, slouched, and leaned to her left. The family member stated she told them she would drive to the facility to see the resident due to the differing reports from the AP and the facility stating the facility’s report was “way worse” than the AP’s. The resident’s family member stated although she was not in the health care field, she immediately recognized the resident was having a stroke stating, “they saw her daily and they should know when something was not right.”

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. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP refused to be interviewed.

Action taken by facility:

The AP no longer is employed at the facility. The facility conducted an internal investigation and re-educated staff on stroke signs and symptoms.

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
Winona County Attorney
Winona City Attorney
Winona Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28896	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR LOAF SENIOR LIVING	765 MENARD ROAD WINONA, MN 55987

(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 ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL288969133C/#HL288961620M On July 11, 2024, 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 82 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL288969133C/#HL288961620M, tag identification 2360.	0 000	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: 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	No plan of correction is required for this tag.	