Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294701840M
Compliance #: HL294709642C

Date Concluded: July 17, 2024

Name, Address, and County of Licensee Investigated:
Silvercrest Properties LLC
16880 Klamath Trail
Lakeville, MN 55044
Dakota County

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

Evaluator's Name: Willette Shafer, 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) neglected the resident when the AP observed signs of a stroke, failed to assess the resident and call emergency medical services for two hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. During the AP's initial assessment, the resident was assessed to have equal strength, able to communicate but was tired and weak The AP planned to have the resident evaluated by the resident's primary care provider (PCP) that morning. An hour later when the AP received report of further decline with observable symptoms, she directed a registered nurse (RN) to assess the resident. The facility staff called emergency medical services and the resident transported to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's primary care

provider and family member. The investigation included review of the resident's medical record, facility incident report, facility policies, death record, personnel files, and staff schedule. Also, the investigator toured the facility and observed medication administration, staff assistance during a meal, and morning cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, generalized weakness, atrial fibrillation, congestive heart failure, and hypertension. The resident's service plan included assistance with bathing, dressing, grooming, and transferring to wheelchair. She was independent with eating.

The resident's progress note written by the AP at 8:35 a.m., indicated she assessed the strength and speech of the resident. The AP wrote she planned for the resident's PCP to evaluate the resident when she arrived at 10:00 a.m. during rounds. At 9:32 a.m., the AP wrote the resident had further changes in condition. The RN noted the resident had right sided weakness, leaned toward her weak side, had difficulty swallowing, and slurred speech. Staff sent the resident to the hospital.

During an interview, the unlicensed personnel (ULP) said he assisted the resident with morning cares. He observed the resident was weak, tired, and was not her usual self. He reported his concerns to the AP, who was a RN. He observed the AP assess the resident's verbal communication, and strength but denied observing the AP assess vitals. The resident was brought to the dining room where the ULP attempted to feed the resident. The resident had difficulty swallowing and was unable to eat or drink. The resident was sent to the hospital.

During an interview, the AP said after the ULP assisted the resident out of bed, he brought her to the AP's office and reported a change in condition. The AP assessed the resident's strength, and verbal communication. Her strength was equal, and she was able to communicate. The AP planned to have the PCP evaluate the resident when she arrived in the morning. The resident was brought to the dining room for breakfast. After a morning meeting, a second ULP reported concerns to the AP. The AP directed the RN to assess the resident while in the dining room. The RN assessed a decline in the resident's health from the AP's initial assessment. Staff called emergency medical services and the resident was transported to the hospital where she was diagnosed with a stroke. The AP stated she did not assess vitals during her initial assessment but stated the resident was in medical distress.

During an interview, the resident's PCP said treatment for a stroke include medications that dissolve a clot. These medications must be administered within the first few hours of signs and/or symptoms. Since the resident woke up exhibiting a change of condition, there was no way to know when symptoms began, therefore earlier intervention may not have changed the outcome.

During an interview, the family member said the facility called, reported the resident had a change in condition and exhibited signs of a stroke. At the hospital, brain scans showed several

areas of the brain impacted by a stroke. The resident was still able to communicate while in the emergency department and declined medication to treat the clots. The resident also declined surgery. She was transferred to the intensive care unit. The family member said the resident was alert and able to make medical decisions. While at the hospital she regained some strength, but she never regained ability to swallow, and she declined a feeding tube. The resident passed away while at the hospital.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility nurses assessed the resident during a change in condition and sent the resident to the hospital.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	29470	A. BUILDING: _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	16880 KLAMATH TRAIL LAKEVILLE, MN 55044

(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****** 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: #HL294709642C/ #HL29470184M On June 4, 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 51 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL294709642C/ #HL29470184M, tag identification 2320.	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.	
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320		

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02320	Continued From page 1 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain vital signs for one of one residents (R1) with a change in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The National Library of Medicine article titled "Vital Sign Assessment," dated May 1, 2023, indicated the first set of clinical examination is an evaluation of the vital signs of a patient. Vital signs provide the degree of derangement that is happening physiologically from the patient's baseline. R1's admitted to the facility January 28, 2020. R1's diagnoses included dementia, generalized weakness, atrial fibrillation, congestive heart failure, and hypertension. R1's service plan indicated she received assistance with bathing, dressing, grooming, and transferring to	02320		

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02320	Continued From page 2 wheelchair. She was independent with eating. R1's progress note dated January 24, 2024, at 8:35 a.m., written by director of nurse's (DON)-A, indicated DON-A assessed strength, and speech. DON-A planned for NP-F to evaluate R1 when she arrived at 10:00 a.m. during rounds. R1's progress note dated January 24, 2024, at 9:32 a.m., indicated R1 had further changes in condition. Registered nurse (RN)-D noted right sided weakness, leaning toward her weak side, difficulty swallowing, and slurred speech. Staff send R1 to the hospital. R1's medical record lacked vitals for the date if incident. During an interview on June 25, 2024, at 10:45 a.m., unlicensed personnel (ULP)-B said he was assigned to provide R1's care the day of the incident. ULP-B assisted R1 out of bed in the morning and said R1 was weak and tired. R1's verbal communication was different. ULP-B brought R1 to DON-A's office. DON-A assessed R1's verbal communication, and strength. ULP-B denied observing DON-A assess vital signs. ULP-B said he brought R1 to the dining room and attempted to feed her. R1 was unable to swallow food or water. ULP-B said R1's mental and physical health remained the same from when he assisted her out of bed until she was sent to the hospital. During an interview on June 6, 2024, at 9:38 a.m., DON-A said ULP-B brought R1 to her office between 7:15 a.m. and 7:30 a.m., after ULP-B noticed a change in R1's condition. DON-A assessed R1's speech and strength but denied taking vitals. R1 was brought to the dining room	02320		

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02320	Continued From page 3 for breakfast. DON-A went to a meeting where she reported R1's change of condition and plan to have R1's nurse practitioner (NP)-F evaluate R1 when she arrived. After DON-A returned to her office, the memory care director voiced more concerns of R1's health. DON-A told RN-D to assess R1. After RN-D assessed R1, DON-A said R1 had changed since she assessed her earlier that morning. DON-A said R1 had garbled speech and she thought R1 had a stroke. R1 was sent to the hospital and passed away a few days later from complications of a stroke. During an interview on June 26, 2024, at 9:45 a.m., NP-F said R1 was sent to the hospital before she arrived. She said RN-F reported she was concerned R1 had a stroke. NP-F said R1 should have been sent to the hospital at the first signs of a stroke. NP-F said DON-A should have taken vitals as part of her initial assessment. R1's vitals may have indicated a serious health concern and supported sending R1 to the hospital immediately. The licensees Incident Report policy, dated August 1, 2021, indicated an incident report must be completed in the event of an emergency. The incident report template included an area to document vital signs. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		