State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304004964M
Compliance #: HL304008556C

Date Concluded: July 31, 2023

Name, Address, and County of Licensee Investigated:
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Carol Moroney RN, Special Investigator

Finding: Inconclusive

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):
Alleged perpetrator (AP) #1 and AP #2 neglected the resident when the staff failed to prevent the resident from falling out of her chair causing a large skin tear and other injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was conflicting information regarding the use of the resident's wheelchair pedals and cushions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice staff. The family interview was also completed. The investigation included review of the resident's medical record and hospice record. The investigation also included review of the security video. The resident was not available for an observation.

The resident resided in an assisted living facility. The resident's diagnoses included stroke, and asthma. The resident's service plan included assistance with a sit to stand lift, escort assistance

in a wheelchair, transferring, bathing, and grooming. The resident's assessment did not address if the resident needed wheelchair pedals on or not during transport and did not address how many wheelchair cushions need to be under the resident.

A video was provided by the facility. The video showed the resident sitting in a wheelchair while AP #1 wheeled her down the hallway when the resident's left foot/toe area got caught on the hallway carpeting. The resident fell forward out of the wheelchair onto the floor, headfirst. AP #1 immediately rendered aid to the resident. The video also showed there were two cushions on the seat of the wheelchair. There were no foot pedals on the wheelchair supporting the resident's feet during transport.

AP #1's personnel file indicated required training and competencies were completed as required.

During investigative interviews, multiple staff members stated the resident does not use wheelchair foot pedals. The resident used both feet to maneuver around in her wheelchair at times and it was believed by the staff interviewed this was good for the resident. Multiple staff also reported the facility used two cushions on purpose as they thought one was necessary and the family requested, they also use their cushion as well. The staff reported after the fall, the resident was immediately reassessed, and the foot pedals were added to the care plan for staff to use the wheelchair foot pedals.

During an interview, the facility nurse stated the event happened early in the morning. The staff got the resident up and was wheeling her to breakfast. The resident's foot got caught on the carpet. The staff person tried to catch the resident but was not able to do so. The resident got a skin tear and hit her head which resulted in a hematoma. The resident was assessed by a nurse. Previously, the nurses had assessed the resident every 90 days and did not think it was necessary to have the foot pedals on the chair. Also, the resident did not wish to have the foot pedals on. There was a grey seat cushion on the chair for her comfort, and there was a harder grey cushion on the resident's wheelchair that the family requested she also have on her chair.

During an interview, AP #1 stated she was bringing the resident to breakfast. The resident's shoes got caught on the carpet and she fell forward. She tried to catch her but was not able. The cushions that were in her chair were the same two cushions that were always in her chair. AP #1 said one of the family members requested the second cushion. The resident's shoes worn at the time of the incident were the ones she normally had on.

During an interview, AP #2 said she was that she was not in the building at the time of the event.

During an interview, the hospice nurse stated upon arrival the resident was sitting in the wheelchair. The hospice nurse noted the family had not been notified so she contacted the family. The hospice nurse stated the resident had a large skin tear near her elbow on the left

arm. The hospice nurse stated the resident had hit her head as well. The hospice nurse dressed the skin tear, and stated the normal hospice case manager would reassess it until it was healed.

During an interview, the resident's family stated no additional cushion was requested for the facility to use on the resident's wheelchair. The family said the resident should have had foot pedals on but had not discussed it with the facility.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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 was not available.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reassessed the resident. The facility updated the resident's plan of care for staff to always use foot pedals, and for the staff to not put two cushions under the resident. The staff were educated on the changes and the instructions were added to the care plan for the staff to use as a reference.

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.

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
	30400	A. BUILDING: _____ B. WING _____	C 07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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: #HL304008556C/HL304004964M On July 7, 2023, 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 10 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL304008556C/HL304004964M tag identification 0250 and 0700.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 250 SS=D	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide requested records during a complaint investigation. The licensed failed to provide records for one of one resident (R1) and for one of two employees, unlicensed personnel (ULP)-G reviewed. 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) 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: R1's medical record was reviewed. R1's diagnoses included stroke and dementia. R1's care plan printed July 7, 2023, indicated R1 required staff assistance of one for mobility and used a wheelchair.	0 250		

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0 250	Continued From page 3 R1's progress note dated January 21, 2023, at 8:00 a.m., ULP-F documented in R1's record R1 was being wheeled out to breakfast, her shoe caught the carpet and she fell out of her chair onto the floor in the hallway outside her room. ULP-F notified the licensed practical nurse (LPN). R1 had a lump on her left forehead, skin tear on her left arm elbow crack area along with bruising above her skin tear on her arm. ULP-F notified the hospice registered nurse (RN). The hospice RN and the LPN assessed R1. On July 7, 2023, at 8:15 a.m., during entrance conference with licensed assisted living director (LALD)-A the investigator requested facility documents. LALD-A stated the investigator needed to request records from the nurses. On July 7, 2023, at 10:09 a.m., RN-B stated to request resident and employee records from LPN-C. RN-B stated she did the investigation regarding R1's fall. A request was made for the facility incident report and the documented internal investigation to be emailed to the investigator. RN-B stated she would send it. On July 10, 2023, at 9:55 a.m., an email request was sent to LPN-C requesting ULP-F and ULP-G's background study, current job description, documentation of annual performance reviews, and all training records. A request was also made for R1's incident report and the investigation. The licensee failed to provide R1's internal investigation. On July 13, 2023, received ULP-F's records by email from LPN-C.	0 250		

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0 250	Continued From page 4 On July 13, 2023, at 11:13 a.m., a second email was sent to LPN-C requesting ULP-G's background study, current job description, documentation of annual performance reviews, and all training. On July 13, 2023, at 11:38 a.m., LPN-C responded by email stating ULP-G was not involved in the incident. LPN-C did not send any further documentation. The licensee failed to provide ULP-G's employee records to include: - background study, - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. - documentation of annual performance reviews that identify areas of improvement needed and training needs, and - all training documentation. The licensee did not provide ULP-G's documents as requested. TIME PERIOD FOR CORRECTION: Seven (7) days	0 250		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	0 700		

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0 700	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three residents (R2, R3, R4's) personal information and amount owed to the facility information was kept private. 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) 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: On July 7, 2023, the investigator initiated an investigation. During the investigation, R1's family member reported the facility had sent out billing information about R1. On the same document were the names and financial information regarding R2, R3 and R4. On July 11, 2023, at 11:00 a.m., R1's family member provided a copy of the billing notice. On July 17, 2023, the facilities owner and licensed assisted living director (LALD)-A stated yes R1's family let her know that the mistake had been made. LALD-A also stated it was just a mistake. LALD-A stated everyone makes a mistake. LALD-A also stated she normally crosses off the other residents' names and said it was just a mistake. The licensee did not provide a policy.	0 700		

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0 700	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		