Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307655461M
Compliance #: HL307657580C

Date Concluded: October 11, 2024

Name, Address, and County of Licensee Investigated:
Arbor Lane
13810 Community Drive
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Julie Serbus, 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 did not follow the resident's service plan and provide scheduled safety checks or toilet the resident on the overnight shift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator was responsible for the maltreatment. The alleged perpetrator documented the resident's cares as completed but did not actually perform them on the overnight shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the legal guardian. The investigation included review of resident's service plan, assessments, services received, death record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator completed an onsite visit and reviewed video footage recording during the night of the incident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, congestive heart failure, weakness, and history of falls. The resident's service plan included assigned staff to be oriented to the plan of care for assigned residents, face to face safety checks every two hours, transfer assistance, and physical assist with toileting scheduled three times on the overnight shift. The resident was enrolled in hospice cares. The resident's assessment indicated the resident does not know her own limitations regarding her safety and attempts to self-transfer herself.

The facility incident report indicated the resident was found deceased in her apartment near the doorway by a staff member on the morning shift. The report indicated the resident was not checked on during the scheduled safety checks during the overnight shift nor was she toileted.

The service delivery record indicated the alleged perpetrator, who was a unlicensed caregiver assigned to provide the resident's cares that shift, signed off overnight tasks as completed to includes four "safety checks" at 12 a.m., 2 a.m., 4 a.m., and 6 a.m., three "toileting assist" tasks at 12 a.m., 3 a.m., and 6 a.m., along with "homemaker services" at 6 a.m. prior to ending her shift.

The alleged perpetrator's time punches indicated the alleged perpetrator punched in at 11 p.m. and punched out at 7:15 a.m. the next morning.

During an interview, unlicensed caregiver #1 stated when she came on to the morning shift, she checked the resident's service plan and went into the resident's room to provide morning cares. Caregiver #1 stated she found the resident lying on the floor inside her apartment door, unresponsive with no pulse and not breathing. Caregiver #1 stated the pendant is usually worn as a necklace, but she found the resident's pendant on a television stand. Caregiver #1 contacted hospice services and facility triage nurse to report incident.

During an interview, a manager stated the alleged perpetrator was the primary caregiver scheduled on the unit.

During an interview the alleged perpetrator, who was an unlicensed caregiver, stated she had not previously worked an overnight shift for the facility prior to this night. The alleged perpetrator stated her usual shift was the 3 p.m. to 11 p.m. where she did care for the resident on that shift. The alleged perpetrator stated care sheets were available electronically to determine cares to be rendered to the resident on a shift. The alleged perpetrator stated she relied on her co-worker, unlicensed caregiver #2, who was a medication administration floater aid on the shift who told her to not disturb the resident throughout the overnight and that the resident would use her call pendant is she needed assistance. The alleged perpetrator stated she did not toilet or check on the resident her entire shift but did sign off services that were scheduled during the overnight.

During an interview, a facility nurse stated she completed the internal investigation. The nurse stated the alleged perpetrator indicated she followed directions other staff on the night shift had provided her and did not follow the service plan which was updated and what staff are taught to follow.

During an interview, the resident's guardian stated the resident slept in her electric lift recliner and not in her bed. The guardian stated the resident had recent declines in her abilities and more confused.

The investigation included attempts to interview unlicensed caregiver #2 but without success.

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided the alleged perpetrator with verbal education ensuring they follow care plans and cannot falsify documents. Additionally, the facility reinforced this with caregivers during daily stand-up meeting by and reviewed with all staff the importance of following resident's service plans at all times.

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. 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.

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
Dakota County Attorney
Burnsville City Attorney
Burnsville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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 Onsite 10/1/24 ******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: HL307657580C/#HL307655461M On October 1, 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 44 residents receiving services under the provider ' s Assisted Living with Dementia Care license.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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
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	See Public Report for details.	