Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319689949M
Compliance #: HL319688155C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living
3030 Southlawn Drive
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Brooke Anderson, 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 facility neglected the resident when the resident fell, requested to go to the hospital, and facility staff refused to send her. She was bedridden for two days and facility staff did not respond her pendent calls for help.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell, facility nursing staff assessed the resident, completed safety checks, and updated the medical provider. The resident was sent to the ER three days after the fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, hospital records, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included adult failure to thrive and bipolar disorder. The resident's service plan included assistance with bed making, housekeeping, and medication management. The resident's assessment indicated the resident was cognitively intact with occasional need for redirection and reassurance. The resident's assessment indicated the resident had a history of falls.

Facility documentation indicated the resident was found on the ground near her door. The resident reported she got up to go to the bathroom, got dizzy, fell backwards, and hit her head. Unlicensed staff obtained vital signs and notified the facility nurse of the fall and that the resident reported she hit her head.

A facility nurse assessed the resident the day of the fall. The resident was reassessed by another facility nurse two days after the fall. During the reassessment, the resident reported a bump on the back of her head that caused discomfort and the medical provider was updated. Three days after the fall, the resident complained of being dehydrated and a facility nurse sent the resident to the emergency room (ER).

Hospital records indicated the resident was diagnosed with recurrent falls and anemia (a condition of low red blood cells or hemoglobin, which can cause tiredness, weakness, and shortness of breath). The resident was discharged to a transitional care unit and later returned to the facility.

During an interview, a facility staff member stated the resident pressed her pendent and when she responded to the resident's light, she found the resident on the ground near her apartment door. The resident reported that she hit her head, so the staff member called the facility nurse. The nurse came into the facility and assessed the resident. At the time of the assessment the nurse asked the resident if she wanted to go to the ER and the resident declined. The nurse advised the resident to push her pendent if she needed help. The facility staff member stated that she checked on the resident several times throughout the next two days and the resident did not report any additional concerns.

During an interview, the resident stated her mind wasn't clear at the time of the fall and the days were all "clumped" together. The resident denied pushing her pendent for help in the days after the fall. The resident stated that facility staff came into her room and brought her food but not consistently. The resident did not report any concerns to facility staff because she thought she could just lay in bed and get better but realized she wasn't getting better and was sent to the hospital.

During investigative interviews, facility nursing staff stated the resident was assessed after the fall and initially declined transport to the ER. Nursing staff continued to monitor and assess the resident and when the resident reported she had a bump on her head, the medical provider

was updated. Three days after the fall, the resident reported concerns and staff noted a change in condition and the resident was sent to the emergency room.

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: Yes.
Family/Responsible Party interviewed: No, attempts to interview were unsuccessful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed the resident, administered pain medication, updated the provider, and sent the resident to the emergency room when a change in condition occurred.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	31968	A. BUILDING: _____ B. WING _____	C 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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 On April 16, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL319688155C /#HL319689949M. No correction orders are issued	0 000		