

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350495361M
Compliance #: HL350497341C

Date Concluded: September 30, 2024

Name, Address, and County of Licensee

Investigated:

Eden Prairie Senior Living
8480 Franlo Rd Apt
Eden Prairie, MN 55344
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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 he was transported to the hospital after sustaining a brain bleed and hemorrhage from a fall the night before.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident fell the night before and was sent to the hospital the next morning when the nursing staff evaluated him and observed a laceration on the top of his head, as well as changes in his behavior. He returned to the facility two hours later with no significant injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, and toileting. The service plan also included he was the high fall risk and needed to use his walker all the time. The resident's assessment indicated he was independent with transfer and mobility using four wheels walker.

Late one evening, an incident report indicated the resident was found on the floor in his apartment during rounds. At that time, staff members observed an abrasion on his forehead and attempted to check his vital signs, but the resident refused. He denied pain and was able to ambulate with a walker as per his baseline. The nurse and family were notified the same night.

The next morning, the progress notes indicated the facility nursing staff assessed the resident, observed the abrasion on his head and a change in his behavior such as having difficulty taking his medication and that he did not want to eat. The same document indicated the resident was sent to the hospital via ambulance.

The hospital records indicated the resident had multiple falls in the last two months, including a prior intracranial hemorrhage. The same documents indicated a computed tomography (CT) scan showed no acute intracranial findings (no internal head injuries). The resident appeared well, moved all four extremities, and reported no significant pain. The physician found no other issues requiring further intervention or admission to the hospital and the resident returned to the facility the same day.

During an interview, a family member stated the resident had fallen three times in the last three months. The most serious injury occurred when he fell three months ago and hit his head. She said the facility did a good job caring for him when he fell. The facility called her, notified the doctor, and sent him to the hospital as needed.

During an interview, a staff member stated that he found the resident on the floor after the resident had fallen off the chair late one evening. The staff member said he notified the nurse and called the family. At that time, he observed a small scratch on the resident's head. He said the resident seemed fine, and he handed off the report before leaving.

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: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility notified the physician and the family member. The nursing staff assessed the resident and sent him to the hospital due to a change in his mental status.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35049	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2024
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NAME OF PROVIDER OR SUPPLIER EDEN PRAIRIE SENIOR LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8480 FRANLO ROAD EDEN PRAIRIE, MN 55344
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(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	<p>Initial Comments</p> <p>On September 11, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL350495361M/HL350497341C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____