



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352943484M

Date Concluded: June 5, 2023

Compliance #: HL352945631C

Name, Address, and County of Licensee

Investigated:

Souriyathy Housing with Services
6231 Sunny Lane
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Juliet O'Martins, RN, Special Investigator
Maerin Renee, 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):

Facility staff neglected the resident when the resident developed deep pressure wounds that eventually required hospitalization. The resident subsequently died.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident developed pressure wounds, the resident frequently declined care. Staff members attempted to provide care as ordered, encouraged the resident to adhere to his care plan, assessed the resident appropriately, and coordinated care with family members and external providers in a timely manner.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a family member. The

investigation included review of medical records and reports, policies, and incident reports. Also, the investigator observed staff interactions with residents, and cares.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, bed sores, and a urinary tract infection. The resident's service plan included assistance with activities of daily living, ambulation, housekeeping, laundry, behavior management, and medication management. The resident's assessment indicated vulnerabilities due to visual, hearing, and cognitive disturbances and an inability to ambulate without assistance. The assessment also indicated the resident was verbally aggressive toward staff and family members and resisted change.

A facility assessment indicated the resident developed wounds on his coccyx (sacrum) and left toe. Contributing factors included the resident's restricted movement and preference to lie on his back. Wound clinic orders indicated the resident received orders for a daily dressing change to his left toe. A wound vac was ordered for the sacral wound, managed by a home health care agency.

A later assessment indicated the resident became weak and lethargic. The resident declined to see his primary care provider for further evaluation. A progress note indicated the resident's family tried to encourage him to see his provider. The resident was hospitalized the following day.

Hospital notes revealed the resident received new medications and placement of a foley (urinary) catheter. The notes indicated the resident was bedridden at baseline with chronic pressure wounds and was admitted for management of septic shock. The resident was prescribed antibiotics and was discharged with orders to continue with the wound vac treatments for the sacral wound three times a week.

Post-hospital follow-up indicated the resident required skilled nursing care, physical therapy, occupational therapy, and speech therapy. A general surgery report indicated a diagnosis of a stage 3 pressure sore to the resident's buttocks (sacrum). Progress notes indicated the resident had low blood pressure, did not want to eat, did not want to be changed, and wanted only sweets for meals. The resident again declined further assessment at his clinic or the hospital.

The resident returned to the hospital approximately a month later, for further assessment of low blood pressure and pain from the sacral wound. Hospital records indicated the resident was critically ill and had also developed respiratory failure due to fluid overload. After talking with the family, the resident transitioned to comfort care. The resident eventually passed away.

The medical examiner report indicated the immediate cause of death was septic shock and urinary tract infection. The manner of death was documented as natural.

When interviewed, staff members stated the resident had a history of declining cares and disinterest in adhering to his plan of care. Staff were in frequent communication with the resident's family members because family members were occasionally able to convince the resident to cooperate with cares.

During an interview, the family member stated the resident "would show his temper" when staff attempted to assist him with cares. Family members were occasionally able to encourage the resident to cooperate with staff, but for the most part, the resident remained resistant to help. The family member believed staff provided competent, culturally sensitive care.

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: Not Applicable.

Action taken by facility:

The facility coordinated care with the hospital, home health care, the resident's external providers, and family.

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: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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 11, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL352945631C/#H352943484M. No correction orders are issued.	0 000	<p>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</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE