Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL38783343M
Compliance #: HL387833520C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Camilia Rose Assisted Living
11800 Xeon BLVD NW 205
Coon Rapids, MN 55448
Anoka County

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

Evaluator's Name:
Jana Wegener, 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 a resident when they failed to call 911 for several hours when the resident was unresponsive and having stroke symptoms. The resident was transferred to the emergency department for evaluation and treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was walking the halls and was provided a chair where he remained seated, but moving around, until unlicensed personnel (ULP) staff identified the resident was unresponsive approximately 45 minutes later. Immediately staff called the nurse who instructed them to call 911. Law enforcement/emergency medical staff (EMS) arrived on scene approximately 12 minutes later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), hospital records, facility internal

investigation, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed the resident and staff in the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including dementia, seizure disorder, syncope, encephalopathy, and Parkinson's syndrome.

The resident's assessment indicated the resident was cognitively impaired, disoriented to time and place. The assessment indicated the resident was independent with mobility, transfers, ambulation, and wandered when confused.

The resident's care plan at the time the incident occurred indicated the resident was independent with transfers, mobility, and walking, but needed occasional stand by assistance with walking related to decreased balance related to Parkinsonism.

The resident's progress notes indicated the resident was restless and wandering during the night.

A police report indicated they responded to a medical concern for an unresponsive resident with shallow breathing. The report indicated the resident was seated in a chair by the nurse's station with a weak pulse, unable to hold his head up, with stroke like symptoms and indicated staff reported the resident had been like that for several hours but no one called 911.

A facility investigation indicated video surveillance prior to and at the time of the incident were reviewed which showed the resident wandering the halls, then was provided a chair around 6:08 a.m. The video showed the resident interacting with staff until 6:44 a.m. Then, a few minutes later at 6:58 a.m. the resident was noted to be unresponsive with shallow breathing, ULP staff called the nurse, then 911. The investigation indicated 911 was called at 7:07 a.m., and law enforcement arrived on scene at 7:11 a.m. The investigation indicated staff were observed tending to the resident until law enforcement/EMS arrived.

A review of facility recorded video footage confirmed the facilities investigation findings. The video indicated there was no neglect or delay in response to the resident's needs.

Interviews with ULP staff who were caring for the resident at the time the incident occurred stated the resident was ambulating the halls and interacting with staff until a short time before being found unresponsive. Staff stated as soon as the resident was found unresponsive, they immediately called the nurse who instructed them to call 911. The staff stated they stayed with the resident until help arrived a few minutes later.

When interviewed the resident's family member stated staff responded appropriately to the resident when he became unresponsive and expressed no concerns with the care or services the resident received.

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: N/A

Action taken by facility:
The facility investigated the incident, provided education to all staff on handling emergency situations and calling 911.

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
	38783	A. BUILDING: _____ B. WING _____	C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE ASSISTED LIVING	11800 XEON BLVD NW COON RAPIDS, MN 55448

(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 May 22, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL38783343M/#HL387833520C. No correction orders are issued.	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.	