Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL388604088M
Compliance #: HL388607001C

Date Concluded: March 29, 2023

Name, Address, and County of Licensee Investigated:

Suite Living Senior Care
3501 Douglas Drive North
Crystal, MN 55422
Hennepin County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
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 Perpetrators (unknown facility staff, AP1 and AP2) abused a resident when AP1 and AP2 inappropriately transferred a resident with a mechanical lift, causing a broken bone in the resident's back.
In addition, the facility neglected to provide appropriate care to the resident when the resident developed a stage four pressure ulcer, pneumonia, sepsis, and passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were inconclusive. The resident's medical record contained conflicting documentation of whether the resident fell or not. The facility investigation did not identify AP1 or AP2, nor the date of an alleged fall. The resident did experience increased pain with repositioning, transfers, and recalled a moment when staff were assisting the resident with transfer/bed mobility and the pain began. The facility referred the resident to skilled nursing after a nurse identified a pressure ulcer. Although the resident received skilled nursing wound care three times per week, the wound progressed

to a stage three. Staff stated they followed the service plan for repositioning, but the resident told family they were not providing repositioning. The resident's medical record indicated the resident chose not to follow a recommended diet, which placed the resident at risk for aspiration pneumonia due to swallowing difficulties.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of incident reports, schedules, resident medical records, policies and procedures related to assessments, staff orientation/training, contacting the registered nurse, and maltreatment of vulnerable adults. Also, the investigator observed resident and staff interactions.

The resident lived in an assisted living facility and had diagnoses including multiple sclerosis, chronic obstructive pulmonary disease, and osteoporosis. The resident's service plan included assistance with housekeeping, meals, medication administration, and pain management. The resident required assistance of two staff for bathing, dressing, toileting, incontinence cares, turning/repositioning, and transfers with two staff using a mechanical lift. The resident's assessment indicated the resident was capable of independent decision making and was able to communicate and make her needs known.

The resident progress notes indicated the resident experienced increased levels of low back pain over several days, the facility consulted with family, and had the resident transported to the hospital. The hospital record indicated the resident had a pathological (non-traumatic) fractured vertebrae (lumbar (L) 1) due to osteoarthritis. The hospital did magnetic resonance imaging (MRI), discussed surgical options with the resident and family, and increased the residents pain medications. A speech therapist assessed the resident's swallowing ability and recommended a change in diet (minced and moist food with nectar thick liquids) due to the risk of aspiration (when food, drink, saliva, or vomit enters the lungs). The speech therapist explained the risks of aspiration pneumonia, but the resident prioritized her quality of life over the risk of aspiration.

The doctor ordered weekly physical and occupational therapy to improve the resident's strength for repositioning/transfers and discharged the resident back to the facility.

Approximately one week later the resident developed an open area on her bottom, which was assessed by a facility nurse to be a stage one pressure ulcer (affecting the upper layer of skin, but not yet broken through the skin). The doctor ordered skilled nursing from a home care agency to come into the facility to provide wound care three times per week.

A skilled nursing progress note five days later indicated the residents wound was a stage two (characterized by a break in the top two layers of skin) with no signs of infection.

The resident progress notes indicated the resident experienced nausea and vomiting for two days, with minimal relief using Zofran (an anti-nausea medication). The facility consulted the family and sent the resident to the hospital. The resident passed away due to respiratory failure contributed by septic shock and pneumonia.

During interview, a manager stated the facility investigated the possibility of a fall occurring prior to the resident's first hospitalization. The manager stated the resident could not specify which day she first noted an increase in pain, which staff had transferred her, or which shift there was a problem on when staff transferred her with the mechanical lift. The manager stated during the investigation she interviewed all possible staff, but they identified no incident. The manager stated after discharge from the hospital, physical and occupational therapy worked with the resident on strength training. The manager stated home health nursing came to the facility three times per week to treat the residents pressure ulcer after it was identified.

During interview, a home health nurse stated she provided wound care for the resident's stage three pressure ulcer three times per week for two weeks. The nurse stated the facility staff were not allowed to care for the wound during that time. The nurse stated the resident had the strength to reposition herself from time to time, but the resident reported to her the facility staff did not reposition her every two hours. The nurse stated staff told her they did reposition the resident every two hours according to the resident's plan of care.

During interviews, several staff stated the resident had constant back pain during her stay. The staff indicated the resident required staff take their time and go slowly when turning, repositioning, or transferring the resident. The staff members stated the resident was not difficult to work with, but due to her pain level, the resident would not allow staff to reposition her.

During an interview, a family member stated she moved the resident into the facility because family was familiar with several staff that worked at the facility and knew how to care for the resident. The family member stated shortly after moving in, the resident reported one of the staff grabbed the resident hard while moving her in bed. The family member stated the resident experienced increased pain for a week before going to the hospital, where they discovered a fracture to L1. The family member stated she viewed a document that indicated the fracture happened after a fall. (A communication/order from the resident's medical provider (physician's assistant) described the resident's L1 fracture as "due to osteoporosis and following fall".) The family member stated although the facility told her they investigated without results, she thought the facility knew who caused it and when a fall incident happened. The family member stated that toward the end of her stay at the facility, the resident only wanted to stay in bed, which was her choice. The family member stated she thought the facility did not provide the resident with the level of care the family expected.

During an interview, the resident's medical provider stated she did not receive any communication about the resident having a fall. The provider stated that due to the resident's

osteoporosis diagnoses she had frail bones and due to her muscle weakness related to multiple sclerosis, even a position change or transfer with a mechanical lift could unknowingly cause a fracture.

In conclusion, it was inconclusive whether abuse or neglect occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224.
(2) the use of drugs to injure or facilitate crime as defined in section 609.235.
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

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, the resident passed away.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, AP1 and AP2 were not identified.

Action taken by facility:
The facility investigated the allegation of the resident's fall.

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
	38860	A. BUILDING: _____ B. WING _____	C 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF CRYSTAL LLC	3501 DOUGLAS DRIVE MINNEAPOLIS, MN 55442

(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 March 3, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL388607001C/#HL388604088M. No correction orders are issued.	0 000		