Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390816484M
Compliance #: HL390812157C

Date Concluded: October 17, 2023

Name, Address, and County of Licensee Investigated:
Round Lake Senior Living
1740 Parkshore Drive
Arden Hills, MN 55112
Ramsey County

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

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 and laid on the apartment floor for multiple days before being found by staff. The resident sustained multiple injuries and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to complete safety checks when the resident did not push a button indicating he was okay each day. The resident laid on the floor of his apartment for multiple days before being found. Due to prolonged time laying in the same position, the resident endured multiple permanent debilitating injuries.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement and the resident's family. The investigation included review of the resident's medical record and contract, policies including

vulnerable adult, as well as fall risk and prevention. The investigation also included review of the resident's hospital record and the law enforcement report. Also, the investigator observed staff interactions with residents, cares, and transfers.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease. The resident was a housing only resident and had an assisted living contract. The resident's individual abuse prevention plan (IAPP) indicated the resident walked safely.

The resident's assisted living contract for independent (housing only) residents included a description of the daily safety check program and the resident's decision to opt in. The daily safety check program description indicated participating residents were expected to push a button in their bathroom between the hours of 6:00 a.m. and 10:00 a.m. every morning. After 10:00 a.m., a staff member would call residents who did not push the button. The staff member would contact the resident's responsible party if the resident did not answer the phone. The staff member would also go to the resident's apartment if needed to make sure they were okay. The daily safety check reports were sent each day to the licensed assisted living director (LALD), the assistant LALD, the front desk staff and the director of nursing (DON).

The daily safety check document indicated the resident pressed the button to complete the daily safety check on morning. The next two days, the resident did not respond to the safety check by pressing the button. No staff completed a safety check on the resident over those two days. The third day, the resident again failed to respond to the safety check by pressing the button.

A facility internal investigation indicated on the third day with no response from the resident, two management staff noticed a collection of newspapers at the front desk that belonged to the resident. At 12:00 p.m., the two managers went to the resident's apartment to check on him. They found the resident laying on his bedroom floor and called 911.

A law enforcement report indicated two facility staff members found the resident laying on the floor at the foot of his bed, on his right side. The resident appeared to have vomit or drool pooled around his mouth. The resident also defecated and urinated on himself. The resident appeared to have a swollen right eye and various bruises on his arms and legs. Emergency medical services (EMS) transported the resident to the hospital.

The resident's hospital record indicated the resident remained in the hospital for 33 days. The resident presented with several pressure wounds to both knees, abdomen, right elbow, right shoulder, right cheek, and right hip. In the emergency department (ED), the resident noted numbness in his right hand. The fourth and fifth fingers on the right hand showed evidence of reduced blood flow which physicians suspected was from prolonged pressure from laying on it. The resident's admitting diagnoses included a fall with rhabdomyolysis (a serious medical condition that can be fatal or result in permanent disability which occurs when damaged muscle tissue releases its proteins and electrolytes into the blood). During the hospitalization, the

resident could not walk and required total assistance for bed mobility and transfers. The resident also aspirated (accidentally inhaling food or liquid into the airway) and choked, leading to a transfer to the intensive care unit (ICU) and a feeding tube was placed. Hospital staff also treated the resident for sepsis (an infection in the blood stream), acute respiratory failure, thrombocytopenia (blood clotting), and acute kidney injury (when the kidneys suddenly become unable to filter waste products from the blood). These records indicated a very low likelihood the resident would return to his prior baseline.

The resident discharged from the hospital to a skilled nursing facility's transitional care unit with various orders including a dietary order of nothing by mouth (NPO) with continuous tube feeding, wound care, and physical, occupational, and speech therapy to evaluate and treat.

During an interview, management staff-1 stated at noon every day, a report would be sent to a couple of management staff and the front desk. The front desk staff were responsible for following up, including calling, or going to the apartment to check on the resident. After this incident, the facility changed the daily safety check program process. The change included ensuring all management received the daily report, the facility switched systems and management staff-1 said she personally completed a daily audit of the report.

During an interview, management staff-2 stated at the time of this incident, the LALD, assistant LALD, and the DON were responsible for following up on the daily safety check report. Management staff-2 stated she noticed the resident had not come down for dinner for a couple of days, and his newspapers had been piling up. After asking other staff if they had seen the resident and being told no, management staff-2 gathered the newspapers and walked to the resident's apartment with another management staff member. Management staff-2 found the resident on the floor, laying on his right side. The resident looked pale and had vomit, urine and feces on him. Management staff-2 notified the DON and provided a capful of ginger ale per the resident's request while waiting for EMS to arrive.

During an interview, a family member stated prior to the fall, the resident had tremors on his left side but could do things for himself including driving to the grocery store. Since the fall, the resident had mostly been bedridden, and he had needed help getting into and propelling a wheelchair. The resident developed nerve damage on his right side and could no longer use his right hand and foot from laying on the right side of his body after the fall. The resident also could no longer swallow, and the hospital placed a feeding tube for nutrition. The family member also stated the resident has been to the hospital about five times since the initial hospitalization due to continued issues from the fall like swallowing problems causing pneumonia and multiple urinary tract infections. The family member stated they thought the resident's inability to recover from the fall was due to being left on the floor for multiple days without food, water, or his medications.

During the investigation, the family member sent an email informing the investigator the resident passed away.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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 completed an internal investigation and changed their daily safety check program for independent living residents.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney

Arden Hills City Attorney
Arden Hills Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39081	A. BUILDING: _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROUND LAKE SENIOR LIVING	1740 PARKSHORE DRIVE ARDEN HILLS, MN 55112

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL390812157C/#HL390816484M On August 22, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 65 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL390812157C/#HL390816484M, tag identification 2310, 2360.	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.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide daily safety check services for one of one residents (R1) as elected in the resident's contract. The licensee failed to check on R1 for two full days. R1 was found on the floor and due to prolonged time laying in the same position, endured multiple permanent debilitating injuries. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee March 1, 2023, as a housing only resident. R1's diagnoses included Parkinson's disease. R1's contract dated February 18, 2023, included a document titled Daily I'm Okay Check Program. This document indicated R1 opted into the daily safety check program to receive the daily safety check service. The licensee-provided document titled Daily I'm Okay Check Program - Independent Living, dated December 2022, indicated participating residents were expected to push a button in the bathroom between 6:00 a.m. and 10:00 a.m. daily. Starting	02310		

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02310	Continued From page 2 at 10:00 a.m., residents that had not pushed their button would be contacted via telephone by a staff member. If the resident did not answer, a staff member would contact the resident's responsible party. If needed, a staff member would go to the resident's apartment to verify the resident's safety. The Wellness Check - Daily I'm Okay Check documents indicated on May 1, 2023, at 8:46 a.m., R1 cleared the Daily I'm Okay Check trigger. This report indicated on May 2, 2023, May 3, 2023, and May 4, 2023, R1 did not respond to the Daily I'm Okay Check trigger. These daily reports indicated licensed assisted living director (LALD)-A, assistant licensed assisted living director (ALALD)-C, front desk (FD)-E, and director of nursing (DON)-F received the reports. The licensee staff did not call or check on R1 after he failed to clear the trigger on May 2 and May 3, 2023. An internal investigation indicated on May 4, 2023, at 12:00 p.m., marketing director (MD)-B and ALALD-C went to check on R1 due to multiple newspapers at the front desk accumulating. Staff observed R1 on the floor of his bedroom and called 911. This investigation included a interview with FD-E who reported she had been off work Tuesday and forgot to check it Wednesday since the report went to the junk mailbox. A review of R1's hospital records indicated R1 remained in the hospital until June 6, 2023. R1's diagnoses included a fall with rhabdomyolysis (a serious medical condition that can be fatal or result in permanent disability which occurs when damaged muscle tissue releases its proteins and	02310		

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02310	Continued From page 3 electrolytes into the blood). R1 presented with several pressure wounds to his knees bilaterally, abdomen, right elbow, right cheek, and right hip with bruising. In the emergency department (ED), R1 noted numbness of his right hand, and the fourth and fifth digits appeared cool with evidence of ischemia (dead tissue), suspected due to prolonged pressure from laying on it. During the hospitalization, R1 could not walk and required total assistance for bed mobility and transfers. R1 also aspirated and choked, leading to a transfer to the intensive care unit (ICU) and a feeding tube being placed. Hospital staff treated R1 for sepsis (total body infection), acute respiratory failure, thrombocytopenia (blood clots), and acute kidney injury. These records indicated a very low likelihood R1 would return to his prior baseline in respect to his Parkinson's disease. R1 discharged from the hospital to a skilled nursing facility's transitional care unit with various orders including a dietary order of nothing by mouth (NPO) with continuous tube feeding, wound care, and physical, occupational, and speech therapy to evaluate and treat. During an interview on August 22, 2023, at 1:55 p.m., LALD-A stated the licensee did not have a written policy for the Daily I'm Okay Check Program. During an interview on August 29, 2023, at 11:03 a.m., family member (FM)-D stated R1 signed up for the Daily I'm Okay Check Program, so the expectation was that someone would have checked on him if he did not push the button. Prior to the fall, R1 had tremors on his left side, but he could do things for himself including driving to the grocery store. Since the fall, R1 had mostly been bedridden, and he needed help getting into and propelling a wheelchair. R1	02310		

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02310	Continued From page 4 developed nerve damage on his right side and could no longer use his right hand and foot from laying on the right side of his body after the fall. R1 also could no longer swallow, and the hospital placed a feeding tube for nutrition. FM-D also stated R1 has been to the hospital about five times since the initial hospitalization due to continued issues from the fall like aspiration pneumonia and urinary tract infections. FM-D stated he thought R1's inability to recover from the fall was due to being left on the floor for multiple days without food, water, or his medications. During an interview on August 31, 2023, at 11:05 a.m., MD-B stated she noticed R1 had not come down for dinner for a couple of days, and his newspapers were piling up. MD-B gathered the newspapers and went to R1's apartment with ALALD-C to check on R1. They found R1 laying on his right side on the bedroom floor. R1 appeared pale and have vomit, urine, and feces on himself. MD-B notified the DON and provided a capful of fluids to R1 while waiting for emergency medical services (EMS) to arrive. At the time of the incident, the LALD, DON, and ALALD were responsible for following up on the Daily I'm Okay Check Program report each day. If a resident did not press there button daily, staff were to physically go to the apartment and check on the resident. After the incident, all building directors were added to the email that delivered the daily report. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		

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02360	Continued From page 5	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	