Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL391499867M
Compliance #: HL391498064C

Date Concluded: April 19, 2024

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Prior Lake
5600 Credit River Rd SE
Prior Lake, MN 55372
Scott County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Inconclusive

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 abused the resident when the resident sustained unexplained bruising to her face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect inconclusive. While the resident did develop bruising on her forehead, there was insufficient evidence to attribute the bruises to abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the hospital records, facility internal investigation, facility incident reports, staff schedules, resident progress notes, resident service plan, resident individual abuse protection plan (IAPP), and related facility policy and procedures. The investigator observed direct care staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's, Lewy bodies (abnormal deposits of a protein in the brain), history of falls, and depression. The resident's service plan included hands-on staff assistance of one for set up, cueing and assistance with dressing. This same plan indicated hands-on assistance of one staff for toileting. The resident was primarily independent with transfers but required occasional assistance from a seated to standing or lying position and could reposition herself in bed. The resident required stand by assist of one staff and a two-wheeled walker when walking. The resident has a history of falls with safety checks approximately every 2 hours. The resident's medical record indicated at times the resident transferred herself from bed to recliner to WC and back without calling for assistance.

The facility incident report indicated a nurse observed the resident had bruising on her left forehead, however the cause of the bruising was unknown.

The facility's internal investigation indicated the staff members were asked for written statements. One unlicensed caregiver stated the resident was not herself the day prior and notified the on-call nurse. None of the statements or interviews indicated a fall occurred or been reported, no issues of skin concerns by unlicensed caregivers, the nurse, or therapy staff earlier that morning prior to discovering the bruising. The internal investigation did not identify any other causes of the bruising.

The resident's facility progress notes medical record indicated the resident experienced new onset weakness and confusion the day prior to the appearance of the resident's bruises.

The resident's medication administration recorded indicated the resident was prescribed a blood thinner (a medication which can cause bruising to occur more easily).

During an interview, an unlicensed caregiver, who worked the night shift, stated the resident did not have any falls or injuries overnight. The caregiver stated during rounds the resident's eyeglasses were found on the floor with the lens broken and this was reported to the next shift.

During an interview, a nurse stated she had spoken to the resident in-person that morning and did not observe any bruising at that time.

During an interview, a therapy staff member stated the resident had received physical therapy that morning and during therapy no bruising was observed.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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 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 which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: No, attempted
Alleged Perpetrator interviewed: NA

Action taken by facility:
The facility assessed the resident and conducted an internal investigation.

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
	39149	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF PRIOR LAKE	5600 CREDIT RIVER ROAD SE WHITE BEAR LAKE, MN 55110

(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 19, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL391498064C/#HL391499867M. No correction orders are issued.	0 000		