Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL395707284M
Compliance #: HL395703743C

Date Concluded: March 18, 2024

Name, Address, and County of Licensee Investigated:

Suite Living Senior Care
1645 Windermere Way
Shakopee MN 55379
Scott County

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

Evaluator's Name: Lena Gangestad, 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 he was sent to the hospital with an infected wound on his coccyx (tailbone) and new pressure wounds on both of his heels.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident admitted to the facility with a coccyx wound and an outside home care agency managed. However, the resident developed new pressure wounds on both his heels, which the facility did not identify or address prior to a nurse from a home care agency identifying them just prior to the resident's hospitalization.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of resident's records and the resident's external medical record.

The resident lived in an assisted living facility. The resident was diagnosed with type 2 diabetes and had a full thickness unstageable pressure wound on the coccyx.

The resident's service plan initiated on his admission included checks, changes, and repositioning every two hours throughout the day and night. The same document indicated the resident the resident not oriented to person, place, and time. The resident had a Foley (indwelling) catheter, which was managed by a home health agency [not the facility].

The resident's 2-page individual resident care plan completed dated on his day of admission indicated the resident was independent with repositioning.

The resident's assessment indicated safety checks were conducted every 2 hours throughout the day and night. Wound care his coccyx was scheduled twice weekly and performed by the home health agency.

The medical records indicated approximately two months after the resident’s admission a nurse from the home health agency was there to provide catheter cares but identified pressure wounds on both if his heel. Additionally, she found the coccyx was infected. Subsequently, the resident was sent to the hospital.

A review of the medical records identified no mention of the resident’s pressure wounds on his heels until the day the home health nurse identified them.

Email correspondence from manager #1 indicated the resident's repositioning protocol was initiated three days prior to the discovery of his infection. The email indicated facilitate communicated the resident’s care requirements, caregivers had access to both the resident's service plan and a 2-page care plan. These documents were printed and stored in a three-ring binder labeled with the resident's room number, available at the nursing station for review. Caregivers were assigned to specific residents during each shift and were required to electronically acknowledge their responsibilities. However, she was unable to provide the updated 2-page care plan upon request.

During an interview, the nurse #1 stated it was her first visit with the resident, during which he complained of pain in his heels. She lifted his heels and observed pressure ulcer wounds on both and described them as dark red and very painful. She said when she arrived, the resident's heels were resting on the bed without any elevation. She called 911 and sent the resident to the hospital for further evaluation.

During an interview, the nurse #2 stated the resident had a couple of wounds that were being managed by an outside agency. He said he did not remember the specific location of the resident's wounds. Additionally, he said the resident was bedbound and under hospice care. While he stated the resident was on a two-hour repositioning schedule, he was uncertain regarding whether the caregivers carried it out or not.

During an interview, unlicensed caregiver #1 stated the resident had not been bedbound for an extended period, and she did not believe he required turning every two hours.

During an interview, unlicensed caregiver #2 stated the resident required turning every two hours. She said he frequently sat and dozed off in his chair. Although she could not recall if he had a wound on his coccyx, she confirmed that he did have wounds on his heels. She said the nurse knew about it but did not remember who the nurse was.

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. The resident was deceased.
Family/Responsible Party interviewed: No; attempts were not successful.
Alleged Perpetrator interviewed: Applicable.

Action taken by facility:
No action taken.

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
Scott County Attorney
Shakopee City Attorney
Shakopee Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39570	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF SHAKOPEE LLC	1645 WINDERMERE WAY SHAKOPEE, MN 55379

(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 February 13, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL395707284M/HL395703743C. The following correction orders are issued, tag identification 2310 and 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39570	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF SHAKOPEE L	1645 WINDERMERE WAY SHAKOPEE, MN 55379

(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
02310	Continued From page 1 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 update service plan and provide caregivers clear communication on his repositioning needs on one-of-one resident review (R1). R1 developed bilateral heel pressure wounds which were not identified until just before R1 required hospitalization for infected pressure ulcer located on this coccyx. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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's diagnoses included type 2 diabetes and had a full thickness unstageable wound of the coccyx. R1's care plan dated May 31, 2023, indicated staff to checks, changes, and repositioning every two hours throughout the day and night. R1's two-page care plan dated May 31, 2023, indicated R1was independent with repositioning. R1's assessment dated July 11, 2023, indicated R1 required checks, changes, and repositioning	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39570	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF SHAKOPEE L	1645 WINDERMERE WAY SHAKOPEE, MN 55379

(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
02310	Continued From page 2 every two hours throughout the day and night. The same document indicated R1 had a wound to his coccyx and more bed bound. R1required assist of two with Hoyer for transfers. Wound care was scheduled twice weekly and performed by a home health agency. R1's progress notes dated July 15, 2023, indicated R1's wound had rapidly declined since last assessment July 12, 2023. R1's pad was soaked with yellow and green drainage. R1 was sent to the hospital on the same day. When interviewed on February 21, 2024, at 5:12 p.m., licensed practical nurse (LPN)-A stated she worked for home health care agency, and it was her first visit with R1. She said when she arrived, R1's heels were resting on the bed without any elevation, and he complained of pain in his heels. Upon examination, she lifted both of R1's heels and observed pressure ulcer wounds on both. She described them as dark red and very painful. She promptly called 911 and sent R1 to the hospital for further evaluation. When interviewed on February 26, 2024, at 4:13 p.m., registered nurse (RN)-C stated R1 had a couple of wounds that were being managed by an outside agency. He said he did not remember the specific location of R1's wounds. He stated R1 was bedbound and under hospice care. He also stated R1 was on a two-hour repositioning schedule, however, he was uncertainty regarding whether the staff adhered to this schedule or not. When interviewed on February 26, 2024, at 4:28 p.m., unlicensed personnel (ULP)-E stated R1 had not been bedbound for an extended period, and she did not believe he required turning every two hours.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39570	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF SHAKOPEE L	1645 WINDERMERE WAY SHAKOPEE, MN 55379

(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
02310	Continued From page 3 When interviewed on February 26, 2024, at 4:57 p.m., unlicensed personnel (ULP)-F stated R1 required turning every two hours. She said he frequently sat and dozed off in his chair. Although she could not recall if R1 had a wound on his coccyx, she confirmed that he did have wounds on his heels. She said she told the nurse about it but did not remember who the nurse was. A review of R1's medical record did not identify reference to R1's bilateral heel pressure wounds prior to the day R1 was hospitalized. Email correspondence dated February 29, 2024, from regional director of nursing (RDON), R1's repositioning protocol was initiated on July 12, 2024.The email indicated the facility communicated R1's cares by the service plan and a 2-page care plan, which were printed and stored in three-ring binder at the nurse's station for review. The email indicated the ULPs were assigned to specific R1's during each shift and were required to electronically acknowledge their responsibilities. However, when requested the facility was unable to provide an updated 2-page care plan. Licensee policy titled 6.01 Assessments, Reviews & Monitoring dated August 1, 2022, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) Days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39570	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF SHAKOPEE L	1645 WINDERMERE WAY SHAKOPEE, MN 55379

(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
02360	Continued From page 4 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 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.	