Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393683564M
Compliance #: HL393685880C

Date Concluded: April 24, 2023

Name, Address, and County of Licensee Investigated:
English Rose Suites
9804 Oak Ridge Trail
Minnetonka, MN 55305
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lissa Lin, 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 alleged perpetrators (AP #1 and AP #2) neglected the resident when AP #1 and AP #2 failed to provide toileting assistance. The resident got up from the toilet independently, fell, and died an hour later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's service plan indicated her needs included stand by assistance with walking and transfers, and assistance with toileting every 2 hours and as needed. The resident had a history of not waiting for staff and self-transferring. The toileting policy instructed staff to stand outside the bathroom door while a resident used the toilet. The resident's assessment and service plan did not indicate the resident required supervision during toileting. AP #1 followed policy, the service plan and provided privacy at the resident's request. When AP #1 and AP #2 answered the door for the resident's hospice aid, the resident fell.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted AP #1, AP #2, and the resident's family member for interviews. The investigation included review of the resident's medical records, the internal investigation, surveillance video, policies and procedures. The investigator observed the licensee call pendant alarm system.

The resident lived in an assisted living facility for about one week. Her diagnoses included congestive heart failure, pulmonary hypertension, chronic kidney disease and anxiety. She had hospice services through an external provider. The resident's service plan included toileting assistance every 2 hours and as needed, assistance with incontinence products as needed, nightly reminders to use the toilet, and perineal cares as needed. The resident used a 4 wheeled walker to walk to and from bathroom and needed stand by assistance with walking and transfers. The resident had mild forgetfulness but was easily reoriented and could make her needs known. Her fall history upon admission indicated she had no known falls in the last 90 days. The resident's record indicated she had a witnessed fall without injury her first day at the facility and had used a call pendant alarm.

The staff schedule indicated two staff were scheduled for day shift. One shift started at 6:00 a.m. when AP #1 arrived, and the next shift started at 6:30 a.m. However, AP #2 arrived a half hour late the day of the incident and AP #1 was alone for one hour. After report from night shift, AP #1 logged onto the work computer, checked her personal cell phone for work messages and started to cook breakfast for the residents.

Review of the surveillance footage indicated the resident exited her bedroom alone and used her walker to cross the hallway and entered the bathroom at 6:25 a.m. She wore beige footwear that resembled ankle socks. She was still in the bathroom at 6:37 a.m. when AP #1 walked by and checked on her, dimmed the bathroom lights and left the door open slightly. AP #2 arrived at 6:50 a.m. and at 7:00 a.m. the front doorbell rang. The resident fell out of the bathroom at 7:01 a.m.

AP #1 said the resident did not always use her call pendant alarm to summon staff for help. AP #1 said she listened for the click of the resident's walker wheels on the floor to know if she was up. About 35 minutes into her shift, AP #1 went to answer a call pendant alarm for another resident. As she passed the bathroom, she saw the resident seated on the toilet. AP #1 stopped back at the bathroom moments later to check on the resident. She was still seated on the toilet. She told AP #1 she needed more time and wanted the bathroom light dimmed because it hurt her eyes. AP #1 said she dimmed the light, told the resident she would be back, and closed the bathroom door slightly for privacy. AP #1 said the resident usually took 20 to 25 minutes on the toilet, so she went back to the kitchen to continue cooking breakfast. AP #2 arrived for her shift. AP #1 and AP #2 were in the kitchen when the front doorbell rang. They both answered the door to let the resident's hospice bath aide in. They heard a thud, ran around the corner and found the resident lying on the floor. She was on her right side with her head outside the bathroom door. The resident was alert and wanted to get up. AP #1 and AP #2 called the nurse

and checked the resident's vital signs. During this time the resident had periods of unresponsiveness but then became alert again. The nurse told AP #1 and AP #2 to move the resident back to her bed and said she was on her way to the facility. The nurse contacted hospice, the physician and the resident's family member.

When the nurse arrived at the facility the resident was unresponsive, had secretions from her nose an made "bubbling" noises. The resident died approximately an hour after she fell.

During an interview, AP #1 said she had cared for the resident a few times. AP #1 said the resident's toileting plan was to check and change every two hours and as needed. AP #1 said staff were to keep the bathroom door open and "peek in on them but not hover" and let the residents do as much for themselves as possible. AP #1 said she was shocked when the resident fell and died. AP #1 said she never neglected or abused any resident.

During an interview, the overnight staff member said that was her first time caring for the resident. She saw the resident "scurry" to the bathroom with her walker, but did not recall that the call pendant alarm or bed alarm activated. The overnight staff member said the resident was a "kind of a stand-by assist". A stand-by assist involved getting a resident up and to the bathroom, going into the bathroom with them, waiting, helping wash hands and freshen up, change briefs, assist back to room. The overnight staff member said the overnight shift was unremarkable, she gave AP #1 her shift change report in the morning and left.

During an interview, a nurse said the resident was cognitively intact, aware of how to use the call pendant alarm and should have activated the call pendant alarm for help in the bathroom. The nurse said it was tough for staff to keep tabs on the resident, who was fiercely independent and impulsive. The nurse interviewed AP #1 after the fall.

During an interview, another manager said he did talk about the resident's need for stand by assistance while toileting at the staff meeting but there was no documentation on the meeting or who attended.

During an interview, the family member said the resident was weak from her heart failure diagnosis and needed a lot of physical assistance. She should not have been left alone in the bathroom. She was not sure the resident even had a working call pendant. The family member said the facility did not meet the resident's needs and she is angry about the situation.

The resident's call pendant was not on her or her walker when she fell. It was found in her room. The facility did not have a call pendant or bed alarm reports for any residents.

AP #2 did not attend a scheduled phone interview. An interview subpoena was returned as undeliverable. Review of the internal investigation records indicated AP #2 told management she did not know the resident was up when she arrived to work.

The resident’s death was determined as natural causes by the medical examiner.

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.

Therapeutic conduct: Minnesota Statutes, section 626.5572, subdivision 20
"Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP #1 interviewed; AP #2 did not answer scheduled interview call, subpoena returned.

Action taken by facility:
Staff monitored the resident after her successful self-transfer and offered help. The staff provided privacy at the resident’s request for more time. After the fall, staff followed procedure contacting the nurse prior to moving the resident and provided comfort care. After the event, the facility conducted an internal investigation.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39368	A. BUILDING: _____ B. WING _____	C 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ROSE SUITES	9804 OAKRIDGE TRAIL MINNETONKA, MN 55305

(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 LICENSING 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: #HL393685880C/#HL393683564M On March 7, 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 6 residents receiving services under the provider's Provisional Assisted Living Facility (PALF) license. The following correction orders are issued for #HL393685880C/#HL393683564M, tag identification 1620, 1640, and 1650.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately assess one of one residents, (R1) for falls after she had a fall without injury her first day at the licensee. R1 fell in the bathroom several days later and died. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an	01620		

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01620	Continued From page 2 isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The licensee was issued a provisional assisted living facility license (PALF), effective October 31, 2022 to October 30, 2023. R1's medical record was reviewed. R1's move in date was November 3, 2022. R1's medical diagnoses included congestive heart failure (CHF), chronic kidney disease, anxiety, and pulmonary hypertension. R1 had hospice services. R1's service plan dated November 1, 2022, indicated R1 received stand by assistance with walking and assistance with toileting every two hours and as needed (prn). There was no indication R1 required supervision while toileting. R1's nursing notes dated November 3, 2022, at 11:18 p.m., indicated R1 slid from her bed to the ground while getting up with walker to go to the bathroom and landed on her bottom. R1 called on call light and staff were getting to R1's room when this occurred. Hospice was updated. R1 encouraged to wait for assistance and education to ensure non slip shoes or socks were on while getting up. R1's admission assessment, dated November 6, 2022, completed by director of health services (DH)-B, indicated R1 had no known falls in the last 90 days and failed to include R1's fall on November 3, 2022. No individualized fall	01620		

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01620	Continued From page 3 interventions were in place. During an interview on March 7, 2023 at 1:34 p.m., DH-B said the day before R1 fell and died, there was a staff meeting about R1's need for stand by assistance during toileting. R1 was a new resident and she always needed stand-by assistance. It was an informal meeting with staff to orient them to the residents, including R1. There was no documentation of the meeting topics or who attended. During an interview on April 17, 2023 at 10:00 a.m., R1's family member (FM)-D said she was not contacted about R1's first fall and only found out about it a few days later when she complained to licensed assisted living director (LALD)-A about expectations and staff attentiveness. Review of a training policy and procedure titled Recognition of Client Needs, dated March 18, 2020 indicated caregivers need to communicate changes in a resident's condition to the nurse. Review of a policy titled Service Plan, dated August 2021, indicated resident service plan will be revised if needed based on a resident's reassessments and monitoring. TIME PERIOD TO CORRECT: Seven (7) Days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 4 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the service plan was revised to include stand by assistance during toileting as reported by the nurse for one of one resident (R1) reviewed. The licensee also failed to ensure the resident's service plan was revised to reflect hourly safety checks and shift change safety checks staff were expected to conduct. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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	01640		

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01640	Continued From page 5 situation has occurred only occasionally). The findings include: Toileting R1's service plan dated November 1, 2022, indicated R1 received stand by assistance with walking and assistance with toileting every 2 hours and as needed (prn). There was no indication R1 required supervision while toileting. R1's move in date was November 3, 2022. R1's medical diagnoses included congestive heart failure (CHF), chronic kidney disease, anxiety, and pulmonary hypertension. R1 also had hospice services from an external provider. R1's nursing notes dated November 3, 2022, at 11:18 p.m., indicated: R1 slid from her bed to the ground while getting up with walker to go to the bathroom and landed on her bottom. R1 pressed her call light as staff were getting to her room when this occurred. Hospice was updated. R1 was encouraged to wait for assistance and education to ensure non slip shoes or socks were on while getting up. R1's admission assessment dated November 6, 2022, completed by director of health services (DH)-B, indicated R1 had no known falls in the last 90 days. No individualized fall interventions were documented. R1's walking mobility indicated R1 needed occasional supervision/stand by assist. R1's toileting needs included assistance with peri-care, however no indication R1 needed supervision while toileting. An incident report dated November 9, 2022, at 7:10 a.m., indicated R1 was up to use bathroom,	01640		

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01640	Continued From page 6 unlicensed personnel (ULP)-F told R1 she would be back and left to answer another call light. ULP-F escorted the hospice aide to R1's room for a shower and both heard R1 fall to the floor. R1 hit her head and died shortly after. During an interview on March 7, 2023, at 1:34 pm., DH-B said the day before R1 fell and died, there was a staff meeting about R1's need for stand by assistance during toileting. R1 was a new resident and she always needed stand-by assistance. It was an informal meeting with staff to orient them to the residents, including R1. There was no documentation of the meeting topics or who attended. A document titled Internal Investigation regarding R1's incident, dated November 9, 2022, indicated administrator (AD)-C and DH-B interviewed ULP-F. ULP-F said she did a stand by assist with R1 and stayed in the bathroom with her for 5 minutes before leaving R1 because she needed more time. ULP-F indicated she was at a staff meeting the day before when licensed assistant living director (LALD)-A, stated caregivers should remain outside of the bathroom door and be able to see R1 when he used the toilet. ULP-F indicated she did not directly watch R1 from the hallway the whole time, she left R1 on the toilet to start breakfast. During an interview on April 17, 2023, at 10:00 a.m., family member (FM)-D said R1 was weak and tired from her CHF and needed physical assistance. Staff should not have left R1 alone even if R1 said she was fine. Review of a policy titled Toileting Assistance, dated August 2021, read: either stay with the	01640		

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01640	Continued From page 7 resident while on toilet or stand near the door, slightly ajar, to maintain resident in line of sight for fall precautions. Safety Checks R1's service plan dated November 1, 2022, indicated R1's services included: bathing, shampoo, personal care (dressing, oral hygiene, shave, hair, make up, nail), foot soak and massage, assist with walking, exercises, feeding, toileting, and body positioning. Review of R1's services delivered report dated November 1 through November 9, 2022, indicated on November 8, 2022, R1 had scheduled hourly checks (5 minutes) overnight and they were completed by ULP-E at 5:03 a.m. on November 9, 2022. (A note at the bottom of the services delivered report page read: "Times reflect the time charted, not necessarily the time actually completed".) On November 9, 2022 at 6:54 a.m. ULP-F documented an end of shift report was completed . During an interview on March 13, 2023 at 3;05 p.m., ULP-E said she and ULP-F did not do a change of shift round together at 6:00 a.m. because she had completed a safety check an hour earlier and everyone was sleeping and ok. ULP-E said R1 had used the toilet around 5:30 a.m. ULP-E said the end of shift round included a documented shift report, an oral report and safety checks to ensure the bed alarms were on. ULP-E said management told staff as long as they could	01640		

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01640	Continued From page 8 see the residents on the room monitors and they appeared to be sleeping staff did not have to physically round. During an interview on March 30, 2023 at 2:00 p.m., ULP-F said ULP-E gave her a verbal report from the overnight shift and left. During an interview on March 14, 2023 at 10:24 a.m., AD-C said staff do hourly safety checks at night and every two hours for dryness checks. Room monitors are turned on at bedtime and off in the morning. Nothing was recorded in the resident rooms. AD-C said ULP-F and ULP-E did not do shift change rounding as expected. AD-C said she did not know if there was a safety policy in the (policy) book, it is a procedure staff are taught in training. The safety checks and shift change rounds are either written on paper forms that are not kept or electronically documented in the electronic medical record. The licensee did not have a policy/procedure on resident safety checks. TIME PERIOD TO CORRECT: Seven (7) Days	01640		
01650 SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 9 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all the required components for two of two residents (R1, R2) reviewed. R1 and R2's service plans lacked fees for the services listed on their service plans. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39368	A. BUILDING: _____ B. WING _____	C 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 10 R1's medical diagnoses included congestive heart failure (CHF), anxiety, and pulmonary hypertension. R1's service plan dated November 1, 2022, indicated R1 received assistance with bathing and shampooing, twice weekly, daily assistance with personal cares, ambulation, and exercises. R1 received assistance with toileting every 2 hours and as needed (prn) and assistance with body positioning every two hours. R1's Resident Agreement, Summary of Important Terms, dated November 1, 2022, indicated R1's monthly base fee (rent and included services) was $14,750. The Meal Plan was $250. R1's total monthly fee was $15,000. R2's facesheet indicated her intake date was September 26, 2022. The section for diagnoses was blank. R2's service plan dated September 27, 2022, indicated R2 received daily assistance with medication administration, ambulation, and feeding. R2 required staff stand by assistance for toileting every two hours and prn. R2 received hearing aide assistance and a special diet, liquid prep. During an interview on March 7, 2023 at 11:20 a.m., director of health services (DH)-B said the fees were in the assisted living contract and showed the MDH surveyor a copy of R1's service plan and a list of services page in R1's assisted living contract for services not included in the monthly base fee, such as cable TV, hair salon services, 1:1 companion services, 1:1 companion	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 11 service with a licensed practical nurse or registered nurse. During an interview on April 17, 2023 at 10:00 a.m., family member (FM)-D said the fee was $15,000 per month. It was "all inclusive" and FM-D had no idea what services cost individually. A policy titled Service Plan, dated August 2021, indicated all residents receiving services will have a service plan in place; service plans shall include fees for the services indicated in the service plan, fees are all inclusive and not determined by level of care. Fees are outlined in the Admission/Agreement plan. If a change to a monthly base rate changes, an amendment will be created and signed by the resident's responsible party. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01650		