Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366036285M
Compliance #: HL366039471C

Date Concluded: January 22, 2025

Name, Address, and County of Licensee Investigated:
Suite Living SR of IGH
7900 Austin Way
Inver Grove Heights, MN 55077
Dakota County

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

Evaluator's Name: Brooke Anderson, 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 facility neglected the resident when the resident sustained a femur fracture and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident sustained a fracture, there was not a preponderance of evidence the incident was caused by the failure of facility staff to provide necessary care or services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the hospice nurse. The investigation included review of the resident records, death record, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included respiratory failure and morbid obesity. The resident's service plan included assistance with repositioning every two hours, and transfer assistance. The resident's assessment indicated the resident displayed deficits in judgement.

Review of video footage showed the night of the incident facility staff #1 was walking outside the resident's room. The resident was heard yelling "ahhhhhh." Facility staff #1 turned on the light and entered the resident's room and stated "Hey", "Hey, hey, hey, hey."

The incident report indicated the resident was lowered to the floor by facility staff #1.

During an interview, facility staff #1 stated when she was going to complete her rounds, the resident was hanging off the bed. She sat with the resident for a while but couldn't continue to hold her in that position, so she lowered her to the ground. Once the resident was on the ground, she went to get facility staff #2 for assistance to get the resident off the ground. Facility staff #1 stated she called the on-call nurse who advised her to give the resident ibuprofen and fill out an incident report.

During an interview, facility staff #2 stated when she entered the room, the resident's head was towards the bottom of the bed and her legs were towards the top of the bed, underneath the air conditioning unit. Facility staff #2 stated facility staff #1 left the room to call the on-call nurse and she attempted to get the resident's legs out from under the air conditioning unit, but the resident was in too much pain. The resident was later lifted off the floor with the mechanical lift and made comfortable.

During an interview, facility management stated the video footage was reviewed, and the incident was investigated. Facility management stated their investigation did not identify neglect by staff.

The law enforcement report indicated there was no indication facility staff #1 caused the resident to fall, caused any injuries, knew of any injuries, or tried to hide any injury. Facility staff #1 reported the incident to the facility nurse and documented appropriately.

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.

Vulnerable Adult interviewed: No, resident deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident and coordinated with the hospice agency to manage the resident's pain.

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
	36603	A. BUILDING: _____ B. WING _____	C 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR OF IGH	7900 AUSTIN WAY INVER GROVE HEIGHTS, MN 55077

(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 January 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL366039471C/#HL366036285M. No correction orders are issued.	0 000		