Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366034541M
Compliance #: HL366035564C

Date Concluded: September 19, 2024

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: Deb Schillinger RN BSN, 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 incontinence care was not provided causing worsening of skin condition.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility's plan of care was not followed due to the resident's refusals for incontinence care and repositioning.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the home health care nurse and the resident's family member. The investigation included review of the resident record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis (a central nervous system disorder causing weakness, numbness, and a progressive loss of muscle coordination), incontinence and chronic pressure ulcers (a skin injury where prolonged pressure breaks down skin and underlying tissues). The resident's service plan included assistance with medication management, and dependence on incontinence care and mobility. The resident's assessment indicated the resident was oriented but did not always follow the medical provider's instructions or recommendations, was incontinent of bowel and bladder and had wound care provided by an outside home health care agency.

One day, a concern arose that care was not being provided per the resident's plan of care, as the resident was found incontinent multiple times before wound care was to be provided.

The resident's medical record indicated the resident refused cares many times on the days surrounding when wound care was scheduled.

During an interview, the facility nurse stated the resident did refuse repositioning and incontinence cares as offered by unlicensed caregivers. The unlicensed caregivers were instructed to reapproach the resident in an attempt to provide cares, but the resident at times continued to refuse cares.

During an interview, the home health nurse stated the resident should be repositioned and changed every two hours, but the resident does refuse cares.

During an interview, the unlicensed caregiver stated the resident's care plan was to reposition the resident and provide incontinent care as needed, however the resident refused cares many times and typically refused cares two to three times per shift. The unlicensed caregiver stated even with reapproach attempts the resident continues to refuse cares offered.

During an interview, the resident stated he has had chronic skin breakdown for a long time. The resident stated if he was tired or comfortable he refused the care he was offered because he did not want to be moved.

During an interview, a family member stated the facility provided the resident good care and communication with the family regularly. The family member stated the resident has had chronic pressure ulcers for approximately the four years. She is aware the resident refuses care at times when offered.

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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Facility continued to reapproach resident to provide cares as listed on the plan of care.

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 09/09/2024

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 September 9, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL366035564C/#HL366034541M. No correction orders are issued.	0 000		