Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201046303M
Compliance #: HL201049460C

Date Concluded: December 26, 2024

Name, Address, and County of Licensee Investigated:
Elder Homestead
11400 4th Street North
Minnetonka, MN 55343
Hennepin County

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

Evaluator's Name: Holly German, 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 they failed to assess her after a noted change in condition and failed to provide adequate care and services to the resident resulting in her death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed the resident after falls, communicated concerns to the resident's provider and provided cares as the resident allowed. The resident often refused cares, medications, and emergency room evaluations as recommended.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted law enforcement. The investigation included review of the resident records, death record, hospital records, facility internal investigations, facility incident reports, staff schedules, law enforcement report, related facility policy and

procedures. Also, the investigator observed resident cares and interactions with staff while on site.

The resident resided in an assisted living facility. The resident's diagnoses included chronic kidney disease and osteoporosis with pathological fracture. The resident's service plan included assistance with medication administration, meal delivery and bathing. The resident's assessment indicated the resident was alert, oriented, and walked with use of a walker. The resident was her own decision maker and independent with most activities of daily living.

The resident's service plan indicated the resident admitted to the facility on a wellness plan that included nursing assessments as required, staff response to activated call lights, daily safety check, and monthly monitoring of vital signs. Other services were available to the resident as requested via an a la cart pay per service system.

The residents progress notes indicated the resident had multiple falls while residing at the facility and increased weakness from poor appetite. The notes indicated the nurses updated the resident's medical provider and family, along with a review of the incident. Facility leadership implemented interventions after each fall. The facility staff educated the resident on risks and benefits for being evaluated after a fall with hitting her head due to being on blood thinners, but the resident declined. The notes indicated the facility also carried out new orders such as medication changes, lab work and x-ray orders received by the medical provider. The notes also indicated the facility nurse attempted on multiple occasions to meet with the resident to discuss services she felt could be beneficial for the resident to receive, but the resident refused to discuss the options.

A facility incident report indicated the resident had fall approximately one week prior to hospitalization. The resident hit the back of her head and had a cut with some bleeding. The resident also had low blood sugar. The report indicated the resident was non-compliant with interventions.

The resident's progress notes indicated the day before the resident admitted to the hospital, the resident had been vomiting and had critical lab results. The medical provider advised the resident to be evaluated in the emergency room. The resident declined to go to the emergency room.

The following day, the resident's progress notes indicated staff updated the nurse of the resident's continued vomiting, refusals of medications, and refusal to get out of bed. Staff called 911 and the resident transferred to the hospital. The notes indicated the resident passed away at the hospital two days later.

The resident's hospital record indicated the resident likely passed away from mesenteric ischemia (a medical condition where blood flow to the intestines is significantly reduced or blocked, usually due to a narrowing or blockage in the mesenteric arteries) and sepsis (a

life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury.) The notes indicated the resident had profound hypokalemia (a condition where there are low levels of potassium in the blood) and hyponatremia (a condition where there are low levels of sodium in the blood) that was the suspected result of the resident's poor oral intake.

A law enforcement report indicated the resident was estranged from her family and there was no power of attorney in place. The report indicated that once the resident ran out of funds, the facility assisted her to obtain a state waiver to pay for services such as bathing, laundry, medication administration, meals delivered to her door, and housekeeping. The report indicated law enforcement contacted the medical examiner who reviewed hospital notes and determined the resident's injuries were due to self-neglect. The law enforcement officer indicated the medical examiner's findings corroborated his findings at the facility. An autopsy was not performed.

The resident's death record indicated the resident died due to complications of a right hip fracture related to a presumed fall.

During an interview, a registered nurse (RN) stated the resident was very independent and was estranged from her family. The RN stated she felt the resident declined and needed more assistance. The RN was able to have a county assessment arranged to help the resident receive funding for more services. The RN stated the resident slowly began to refuse the extra services. The RN stated the facility delivered the resident's meal trays to her room and a housekeeper notified her of meal trays with the food left on them in the resident's room. The RN stated the provider was notified of their concerns of the resident not eating, losing weight, and feeling dizzy. The RN stated the resident told her it was good for a person to skip meals to shrink their stomach, and the RN educated the resident on the importance of nutrition. The RN stated when the resident had critical lab values, her provider recommended she be evaluated in the emergency department and provided the resident the risks of not going in. The RN stated the resident declined to go, but she still called 911 in hopes the emergency medical staff could evaluate her and convince her to go in. However, the resident continued to refuse to go to the hospital with the emergency medical staff. The RN stated the resident would refuse to allow her to assess her skin and would deny injury after a fall, stating she was fine.

During an interview, a family member stated he had a strained relationship with the resident. The family member stated the resident was non-compliant for receiving care. The family member stated there were previous investigations that resulted in a determination of self-neglect, and he would not put it past the resident to neglect herself to death. The family member stated he would not be surprised if the resident refused to go to the hospital.

During an interview, the licensed assisted living director (LALD) stated the facility had concerns about the resident's personal choices as she did not always make right choices regarding her health. The LALD stated once they had a county waiver approved for the resident, she received

assistance with things like bathing, meal tray delivery, and medications. The LALD stated the waiver paid for the cost of the services and told the resident multiple times the services were covered as she knew the resident previously declined assistance due to the financial burden of paying for them in the a la cart pay for service system she previously used. The LALD stated as soon as they were aware of a fall the resident was assessed for injury and pain. The LALD stated the resident refused to be evaluated at the hospital a few times, including when her medical provider recommended it. The LALD stated the facility also had concerns about the resident drinking alcohol, as it was an issue for her. The LALD stated she saw the resident clearly intoxicated, walking unsteady and smelled alcohol on the resident which contributed to her falls. The LALD stated there were no bruises on the resident reported to her, and believed if there were bruises staff did not see them as the resident had been refusing assistance with bathing so they did not have the chance to see her skin.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed the resident for injury, communicated to the medical provider, completed provider orders as ordered, summonsed emergency medical services as needed, and initiated additional services to help aide the resident.

Action taken by the Minnesota Department of Health:
No further action 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
	20104	A. BUILDING: _____ B. WING _____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER HOMESTEAD	11400 4TH STREET NORTH MINNETONKA, MN 55343

(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 November 22, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL201049460C/#HL201046303M. No correction orders are issued.	0 000		