Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201143303M
Compliance #: HL201143408C

Date Concluded: June 12, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Lakeview Commons
1200 N Lakewood Drive
Maplewood, Mn 55115
Ramsey County

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

Evaluator's Name: Michele R. Larson, 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 they failed to implement fall interventions after the resident returned to the facility from the hospital after a second fall with severe pain. The resident fell again a few hours later and was hospitalized with a spinal fracture in the low back (Lumbar) area, L2. The resident spent two weeks in the hospital and was admitted to hospice when she returned to the facility. The resident died two weeks later from her injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although nursing staff assessed and identified the resident had a history and at risk for falls, they failed to monitor, develop, and implement additional fall interventions to prevent future falls after the resident had three falls within several hours. The resident fractured her spine and was hospitalized. The resident never returned to her baseline after her falls. The resident died a few weeks later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and primary care provider. The investigation included review of the resident's record, death record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares during the onsite visit to the facility.

The resident resided in an assisted living with dementia care. The resident's diagnoses included Alzheimer's disease and a past history of falls with fractures. The resident's service plan included three daily safety checks. The resident was assessed as a fall risk and required a four-wheeled walker when she walked, with staff cues and standby assistance with ambulation. The resident was unable to use the call pendant system and unable to report abuse.

An incident report indicated one morning; staff members found the resident on the floor in her bedroom. The resident was assisted off the floor by two staff members using a mechanical lift. The resident denied hitting her head but complained of severe back pain.

An incident report three hours later, indicated the resident fell in a common area of the facility. The resident was found lying on the floor wearing only briefs, socks, and a top. The resident was incomprehensible and talked non-stop. Facility staff thought the resident may have fallen while trying to take her pants off but were unsure since the fall was unwitnessed. The resident denied hitting her head but complained about severe back and left hip pain. Approximately two hours later, the facility called 911 after the resident had difficulty walking and performing tasks. Emergency medical services transported the resident to the hospital.

The resident's hospital record indicated the resident was discharged back to the facility approximately seven hours later after the hospital found no acute injuries.

The resident's record lacked documentation of new interventions implemented following the first and second fall.

The resident's progress note indicated approximately six hours after returning to the facility, facility staff found the resident on the floor inside her apartment, her third fall within 17 hours. Two staff members assisted the resident off the floor and onto her bed using a mechanical lift and performed range-of-motion on the resident's extremities. Staff documented the resident's range-of-motion was intact. Staff members called the on-call registered nurse who instructed staff to perform range-of-motion a second time and call if the resident complained of pain. Four hours later staff found the resident sitting abnormally in her chair reporting pain in her back and left hip. A staff member reported she checked on the resident "a couple of times" during the night. Emergency services was contacted and transported the resident to the hospital.

The resident's hospital record indicated the resident was diagnosed with a lumbar (L2) spinal fracture. Facility staff reported to the emergency medical service team the resident normally

“ran” around the facility with her walker but was unable to do so after her recent multiple falls. The resident spent two weeks in the hospital and was admitted to hospice upon her return to the facility.

The resident’s death certificate indicated the resident’s immediate cause of death were complications from spinal fractures due to her recent falls.

During an interview, the facility nurse stated she sometimes implemented short-term hourly safety checks for a resident who returned from the hospital during the overnight shift, to ensure staff laid eyes on a resident more often. The facility nurse stated the resident required 1:1 supervision since she was very mobile and often forgot to use her walker. The facility nurse stated she recalled being upset when she heard the resident returned to the facility after her second fall stating, “she typically doesn’t fall three times in one day.”

During an interview, facility leadership stated the resident had poor safety awareness and was unable to safely stand and walk and did not think the resident should have returned to the facility after her second fall.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
When the resident returned to the facility, hospice initiated a mechanical lift, matts on the floor beside the bed, and a Broda (high back and used for positioning) chair.

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
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20114	A. BUILDING: _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKEVIEW COMMONS	1200 NORTH LAKEWOOD DRIVE MAPLEWOOD, MN 55119

(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****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER 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: #HL201147921C/#HL201149887M #HL201143408C/#HL201143303M On April 23, 2024, 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 83 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL201143408C/#HL201143303M, tag identification 2310.	0 000	Assisted Living Provider 144G. 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 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.	

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02310	Continued From page 1	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted 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 ensure the care and services were provided according to an up-to-date plan, and subject to acceptable health care and medical or nursing standards for one of two residents (R2) with records reviewed for falls. R2 had three falls within 24 hours and required hospitalization for a spinal fracture following the third fall. The licensee failed to ensure new interventions were implemented following R2's falls. In addition, facility staff transferred R2 off the floor prior to notifying and being assessed by the nurse. 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: R2's medical record was reviewed. R2 was admitted the licensee's facility on November 1, 2019. R2's diagnoses included Alzheimer's	02310		

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02310	Continued From page 2 disease. R2 resided in the facility's memory care unit. R2's 90-day assessment dated July 7, 2023, indicated R2 was a fall risk due to her history of falls, cognitive loss, walker use, hearing, and vision loss. R2 denied having any pain at the time of her assessment. R2's service plan dated July 23, 2023, indicated R2 required assistance with personal cares, toileting, transfers, and medication management. R2 required a four-wheeled walker and staff stand-by assistance at all times when she walked. R2 received three daily safety checks at 12:00 a.m., 4:00 a.m., and one during the day. R2 was unable to use the call pendant system unless prompted by her family due to her Alzheimer's diagnosis and required frequent redirection. R2 was unable to report abuse or neglect. R2's incident report dated October 2, 2023, at 8:00 a.m., indicated unlicensed personnel (ULP) found R2 on her bedroom floor. The ULP assisted R2 off the floor and onto her bed using a two-person assist and obtained R2's vital signs. R2's blood pressure was 194/117 mmHg. R2 denied hitting head but complained about severe back pain. R2's family member (FM)-E, a facility licensed practical nurse (LPN)), and R2's primary care provider (PCP) were notified three and one-half hours after R2's first fall. R2's record lacked evidence a facility nurse was immediately notified about R2's fall with severe pain, and lacked documentation a facility nurse completed a post-fall assessment. R2's incident report dated October 2, 2023, at 11:09 a.m., indicated three hours after her first fall, R2 fell a second time. ULP found R2 lying on the floor in the common area, wearing only socks,	02310		

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02310	Continued From page 3 brief, and top. ULP documented R2 may have fallen while trying to take her pants off. R2 was incomprehensible and talked "non-stop." Staff documented R2 denied hitting her head, and had no visible injuries, but again complained about severe left hip and back pain. At 12:40 p.m., one and one-half hours later, the facility arranged for R2 to be evaluated at a hospital after R2 had difficulty walking and performing tasks. R2's progress note dated October 2, 2023, at 7:42 p.m., indicated R2 was discharged from the hospital back to the facility at 7:38 p.m. R2's record lacked documentation of a post fall assessment upon R2's return from the hospital, the two falls, along with the development and implementation of interventions to ensure R2's safety. R2's progress note dated October 3, 2023, at 1:42 a.m., indicated R2 was found on her floor reporting pain in her left hip, the third fall in 17 hours. Prior to contacting the on-call nurse, two ULPs assisted R2 off the floor using a mechanical lift and performed range-of-motion (ROM) on her extremities. ULP called the on-call registered nurse (RN) who instructed ULP-C to perform ROM a second time and notify the nurse if R2 complained of pain. Four hours later at 5:23 a.m., ULP-C called the on-call RN indicating she found R2 sitting abnormally in her chair reporting pain in her back and left hip. ULP-C indicated she checked on R2 "a couple of times" during the night. The nurse arranged for R2 to be evaluated at a hospital. R2's hospital record dated October 3, 2023, indicated R2 was diagnosed with a low back (L2) spinal fracture. Facility staff reported to the hospital staff that R2 normally "ran" around with	02310		

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02310	Continued From page 4 her walker but after multiple falls the past few days she was no longer able to do so. R2 spent two weeks in the hospital and was admitted to hospice after she returned to the facility. R2 never returned to her baseline status. R2's progress note dated November 4, 2023, at 7:31 a.m., indicated R2 passed away at 4:00 a.m. R2's death certificate indicated R2's immediate cause of death were complications from spinal fractures due to her recent falls. During an interview on May 16, 2024, at 9:30 a.m., director of nursing (DON)-D stated the facility sometimes increased safety checks when a resident returned from the hospital, but it would "depend on the situation." DON-D stated R2 did require 1:1 supervision since R2 was very mobile and often forgot to use her walker. DON-D stated she recalled being upset when she heard R2 was sent back from the hospital after her second fall stating, "she typically doesn't fall three times in one day." During an interview on May 16, 2024, at 3:30 p.m., licensed practical nurse (LPN)-H stated R2 fell whenever she failed to use her walker. During an interview on May 2, 2024, at 11:00 a.m., Licensed Assisted Living Director (LALD)-F stated R2 had poor safety awareness and was unable to safely stand and walk. LALD-F stated it was an expectation that R2 would have been assessed by a facility nurse after her first fall. LALD-F stated the facility did not think R2 should have discharged back to the facility after her second fall. The licensee policy titled Reporting, Documenting, and Reviewing Incidents Involving	02310		

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02310	Continued From page 5 Residents, dated August 1, 2021, indicated staff were to immediately notify a nurse upon discovering an incident involving a resident. The nurse would complete an assessment of the resident in a timeframe that was reasonable following the incident. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment 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 two resident(s) 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.	