Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205499665M
Compliance #: HL205497663C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Callista Court
1455 West Broadway Street
Winona, Minnesota 55987
Winona County

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

Evaluator's Name: Nicole Myslicki, 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 alleged perpetrator (AP) neglected the resident when the AP did not check on the resident after he failed to flip his safety check sign. Family found the resident unresponsive in his apartment and required emergency services.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The allegation against the AP was not substantiated. Although the AP signed off on a service she did not complete, miscommunication occurred between the AP and another unlicensed personnel (ULP). The facility knew the resident had hip mobility issues, did not wear his pendant, and had a history of falls. Additionally, the facility did not pre-determine which tasks would be assigned to each ULP but instead relied on the ULPs to split up their daily tasks. Regarding the "I'm Okay" check program, staff were unable to confirm if the responsibility fell on all staff or just nursing prior to the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident report, personnel file, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed residents' doors for "I'm Okay" signs.

The resident resided in an assisted living facility. The facility provided resident's record did not identify diagnoses. The resident's service plan included "I'm Okay" checks at 9:00 a.m. and 9:00 p.m. daily. The resident's assessment indicated the resident had a pendant to request assistance 24 hours per day, but he did not wear it. Staff encouraged him to wear the call button and press it for assistance as needed. This assessment also indicated the resident used a wheelchair independently for mobility and transferred himself.

The resident's individual abuse prevention plan (IAPP) indicated the resident had a history of falls and hip immobility but used a wheelchair independently and transferred himself. The resident also had wounds on his coccyx but declined nursing assessment. This IAPP indicated staff would continue to encourage and educate on the importance of nursing monitoring wounds to avoid progression or infection.

The resident's record included a document titled "I'm Okay" Program, which included the process for I'm okay checks. This document indicated the resident would be given an "I'm Okay" card to be put outside his door each evening by 9:00 p.m. As staff completed their duties throughout the building, they were to look for the card indicating the resident was okay. If the resident did not place the card outside the door, staff were to knock and check in on the resident. Every morning by 9:00 a.m., the resident was supposed to take the card back inside the apartment. If the resident did not remove the sign from the outside of the door, staff would then knock on the door and check on the resident. The resident signed this document.

A progress note in the resident's record indicated the resident's family member came to visit the resident and found him on his bathroom floor. The resident did not respond to the family member appropriately and could not answer questions about the fall. The family member called 911 and reported the incident to staff at 3:45 p.m. Emergency medical services (EMS) transported the resident to the emergency department (ED) and later admitted to the hospital.

A second progress note in the resident's record indicated the facility started an internal investigation regarding the incident. Staff last saw the resident at 9:50 p.m. the day before being found on the floor and not at 11:20 a.m., as signed by the AP on the service delivery record.

The facility staff failed to check on the resident at the 9:00 a.m. I'm Okay check and was not seen between 9:50 p.m. the night before until family found him on the floor at 3:45 p.m. the next day.

The resident's hospital record indicated the resident arrived at the ED with a change in mental status after a fall and being found on the ground. He also had a fever of 103.3 degrees Fahrenheit. The resident's hospital diagnoses included methicillin-resistant staphylococcus aureus (MRSA) bacteremia (the presence of bacteria in the bloodstream), rhabdomyolysis (an emergent medical condition in which the muscled are injured and cells burst, releasing proteins into the blood stream, evident by in being in the same position for a long period of time), acute kidney injury, and stage 2 pressure ulcer. The resident's condition worsened despite medical intervention, and he became less responsive. The hospital staff and family transitioned the resident onto comfort cares, and the resident died two days after being found on the floor.

The resident's death record identified MRSA bacteremia as cause of death.

The facility's schedule indicated two unlicensed personnel (ULPs) were scheduled on the day shift, one day prior to the incident. The AP's scheduled shift went from 6:30 a.m. to 3:00 p.m., and the other ULP's shift went from 6:30 a.m. to 1:30 p.m.

During an interview, the director of nursing (DON) identified the I'm Okay check program as something they provided for everyone unless the resident opted out. The DON stated there had been a misunderstanding between the AP and the other ULP regarding which floors were completed regarding the I'm Okay checks for the morning. The DON coached the AP on documenting services she did not complete. Additionally, all staff were educated on the I'm Okay check signs. The DON stated the facility re-educated all staff including culinary, housekeeping, and maintenance department staff regarding the I'm Okay program. The DON did not know if the responsibility of ensuring the I'm Okay signs were brought back in each morning fell on all staff prior to the incident.

During a second interview, the DON stated in general, one to two ULPs were scheduled in the assisted living for the morning shift, depending on the current need. The day of the incident, the facility had a whole shift open for the morning shift. A ULP picked up to work part of the open shift, 6:30 a.m. to 9:00 a.m. that morning. The DON stated the two ULPs were supposed to talk at the beginning of the shift and delineate which tasks each ULP planned to complete. The facility did not pre-determine task assignments or have a process for how the tasks were supposed to be divided. The DON stated it was up to the ULPs to determine which tasks each of them were going to do.

During an interview, the licensed assisted living director (LALD) stated walkies were supposed to be used more for quick communication, not for giving full reports between shifts. The internal investigation found there had been miscommunication between staff regarding the I'm Okay sign, and the AP documented a task she had not completed. The LALD stated every staff should be held accountable for the signs, not just nursing staff. Additionally, the LALD thought every staff being accountable had been part of the process the whole time, and they just needed to remind all staff of their responsibility.

During an interview, a registered nurse (RN) stated she would hear a ULP over the walkies inform the other ULP which floor they completed and ask the ULP to complete the other floor. Overall, face-to-face reporting had been the standard process for end of shift reporting.

During an interview, the AP stated she had been giving a shower to another resident. The other ULP came over the walkie, and the AP thought the ULP stated all the I'm Okay checks were completed. The AP stated she should not have assumed. Later that afternoon, the resident's family member put on his call light. The family member informed the AP the I'm Okay sign had still been on the door. The AP apologized, called the nurse, and stayed until EMS arrived. The AP stated she received re-education and started walking the hallways multiple times per shift to ensure no signs were missed.

During an interview, the resident's family member stated she visited the resident and left about 5:30 p.m. two days before finding him on the floor. The family member did not see or speak with the resident the following day. The day after that, the family member showed up in the afternoon and noticed the "I'm Okay" sign on his door. She let herself into the apartment and noticed the bathroom light on and the door ajar. The family member looked in the bathroom and found the resident lying on the floor on his left side. He had been awake and rubbed his hip but incoherent and unable to speak. His wheelchair had been parked parallel to the bathroom sink with the breaks locked, and the call button hanging on a hook near the shower. The family member pressed the call button and called 911 while she waited for assistance. EMS arrived and transported the resident to the ED. He admitted to the hospital for two days until he passed away. The family member stated the facility had been short staffed the day of the incident. Overall, the resident had been pleased with the facility and thought the staff had been helpful.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility and the AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The facility failed to follow the facility directive and/or policies and procedures.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed education with staff.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20549	A. BUILDING: _____ B. WING _____	C 04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLISTA COURT	1455 WEST BROADWAY STREET WINONA, MN 55987

(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 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: #HL205497663C/#HL205499665M On April 15, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 99 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL205497663C/#HL205499665M, tag identification 2360.	0 000	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 one 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.	