Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL21691001M
Compliance #: HL21691002C

Date Concluded: March 9, 2022

Name, Address, and County of Licensee Investigated:
Roitenberg Family Assisted Living
3610 Phillips Parkway
St. Louis Park, MN 55426
Hennepin County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit: 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.

Allegation(s): The licensee did not provide or follow a therapeutic diet and meal instructions and as a result the resident passed away after choking on food.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility did not ensure the resident's known history of choking and the need for supervision with meals was added to the resident's service plan, although the resident's admission information from her case manager indicated a need for supervision with meals, and facility nurses and other staff members had also subsequently identified the resident was having trouble with eating and swallowing. The resident then consumed a piece of hotdog that was too large, it blocked the resident's airway, and the resident passed away as a direct result of the choking incident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed a case manager and

personal care assistant. The investigator reviewed the resident's records; medical examiner, law enforcement, and EMS reports; and facility policies.

The resident resided on the memory care unit with diagnoses that included Huntington's disease, dementia with behavioral disturbance, repeated falls, localized edema, general anxiety disorder, and major depressive disorder. The resident received assistance with all activities of daily living due to decline in physical abilities due to Huntington's disease.

The resident's Coordinated Services and Supports Plan (CSSP) assessment, prepared for the resident's admission by a case manager, indicated the resident required cueing and supervision from another person throughout the task of eating to assure she did not choke, and required set-up and preparation assistance.

Facility documentation indicated that prior to the incident, a situation had occurred where a staff member saw the resident gasping for air, and the staff member put her arms around her and tried to push up on the resident's chest. The staff member then leaned the resident forward and hit her between her shoulder blades, and an item of food came out. The staff member reported the incident to the nurse and asked the nurse about changing the resident's food. The nurse said she was not able to change a diet, and the provider needed to do so.

The resident's progress note indicated a Registered Nurse (RN) documented the resident had a choking incident and was able to cough out the food. Staff noted the resident swallowed food without effectively chewing it. The RN reminded the resident to chew food more before swallowing. The resident finished dinner without further concerns.

The resident's progress note indicated another nurse documented the resident had a coughing episode and requested an order from the nurse practitioner for speech therapy to come and evaluate for swallowing difficulty. A telephone order form indicated the nurse subsequently took an order from a prescriber for the resident to be evaluated for swallowing.

The resident's service plan assessment indicated the resident required texture modified preparation (pureed, or mechanical soft, and/or thickened liquid nectar, honey, or pudding consistency), and an order was received for speech therapy to evaluate and treat after the resident was noted not to be chewing food effectively.

On the day of the incident, the resident was in the dining room and had been served a hot dog. Another resident alerted staff that the resident appeared to be choking, and staff attempted the Heimlich maneuver and called 911. Law enforcement responded and initiated CPR; the resident was unresponsive at this time. Emergency medical services (EMS) arrived and continued attempting resuscitation, but it was not successful, and the resident died.

The law enforcement report indicated that staff had not initiated CPR when law enforcement arrived, but staff presented documentation the resident's advance directives were for full treatment and resuscitation, so law enforcement initiated chest compressions.

The resident's Minnesota Cause of Death Worksheet indicated the cause of death as food bolus asphyxia.

During an interview, a licensed practical nurse (LPN) stated the resident was on a regular diet and staff would cut up her food and she would feed herself. The LPN stated sometimes the resident would eat too fast, and staff would have to remind her to slow down.

During an interview, an administrator stated speech therapy was scheduled to assess the resident six days after the telephone order was received.

During an interview, an unlicensed direct care staff member stated staff usually cut the resident's food up for her, and staff reported to the nurse the resident needed staff to feed her because she did not swallow what was in her mouth before eating more food. The staff member stated on the day of the incident, another direct care staff member served the resident's food and cut the hotdog in half, and no staff supervised the resident during the meal.

During an interview, the resident's personal care assistant (PCA) stated it was her understanding that staff instructions were to supervise the resident during mealtime. The PCA stated the resident was able to feed herself if you cut her food into dime sized pieces or smaller, however, she needed assistance because she had an impulse problem and would shove food in her mouth. The PCA stated during the resident's nursing assessment they asked her about the resident's needs, and she stressed the concern of the resident's choking hazard.

During an interview, an RN stated the site coordinator received the CSSP after the admission of the resident, and it was the nurses' responsibility to make changes to the residents' service plan.

In conclusion, 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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Deceased
Family/Responsible Party interviewed: No family available
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The staff called 911.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

cc:
The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
St. Louis Park City Attorney
St. Louis Park Police Department
Hennepin County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21691	A. BUILDING: _____ B. WING _____	C 01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROITENBERG FAMILY ASSISTED LIV	3610 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(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 Initial comments ******ATTENTION****** AMENDED ASSISTED LIVING PROVIDER LICENSING 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: HL21691002C / HL21691001M On January 4 2022,, the Minnesota Department of Health conducted a complaint investigation at the above provider. On January 25, 2022, a letter was emailed indicating that no correction orders were issued from this complaint investigation. Upon further review, the complaint investigation substantiated that maltreatment occurred and the orders are amended to add that the following correction order issued for HL21691002C/HL21691001M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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	02360		

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02360	Continued From page 1 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: Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On March 9, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	