

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL232177306M
Compliance #: HL232173882C

Date Concluded: January 19, 2024

Name, Address, and County of Licensee

Investigated:

Regent at Burnsville
14500 Regent Lane
Burnsville, MN 55306
Dakota County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Inconclusive

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 she failed to report to nursing that she performed the Heimlich maneuver on the resident, who choked to death.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. While the AP did not initially report the resident choked when she called facility staff for help, she performed the Heimlich maneuver on the resident. It was inconclusive if the outcome would have changed had other facility staff known the resident choked when they arrived to help. Interviews produced conflicting information on when or if staff were to call 911 for a hospice resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, internal investigation records including statements from facility and hospice staff, policies and,

procedures, and training. Also, the investigator observed residents in memory care and the main dining areas eating and drinking.

The resident resided in an assisted living memory care unit. The resident's diagnoses included malignant salivary gland cancer, brain cancer and dementia. The resident's service plan included assistance with activities of daily living and documenting an unscheduled service if she ate breakfast. The resident's assessment indicated she was wheelchair-bound and had a regular diet with thin liquids. A hospice nurse had assessed the resident and began hospice enrollment, the day the choking incident occurred.

On the day of the incident, the AP said she was in the kitchen area reheating soup for the resident's lunch, which was soup and salad. Another resident at the dining table told the AP the resident needed help. The AP saw the resident was in distress, pulled her a few feet away from the table and began the Heimlich maneuver. The AP phoned the nursing office and the front desk for help but dropped the phone a few times because she was crying and still performing the Heimlich maneuver on the resident. The AP was the only staff member scheduled in the memory care unit for the day shift. The AP said when she finally reached the front desk, she told the staff member to send help but did not relay the resident was choking.

According to records reviewed, the AP performed the Heimlich maneuver alone for about three minutes before she called for help. Approximately two minutes passed from the time the AP phoned for help and staff arrived.

The AP continued the Heimlich maneuver until the resident became unresponsive and "turned colors." Once staff members arrived, after the AP summoned for help, the AP left the unit to compose herself. The facility nurse called Emergency medical services (EMS). When the AP returned to the unit, staff had moved the resident to her room and into her bed. The facility nurse notified the resident's family and physician. EMS arrived approximately 20 minutes after the resident first choked. The hospice nurses returned to the facility and asked the AP what happened since they had just seen the resident that same morning to arrange hospice services. They assumed the resident had died of natural causes, but the AP told them the resident had choked. The AP's report to the hospice nurses was the first time she informed someone the resident was unresponsive due to choking. The hospice nurses let facility management know the resident had choked to death.

Facility management returned to the memory care unit and interviewed the AP, then suspended her for a few days while they conducted an internal investigation. The nurse contacted the family the new information on how the resident died. The nurse contacted the medical examiner's office to take the resident's body for an autopsy.

During an interview, the AP said she was trained on the Heimlich maneuver, but never performed it before that day. She said it was also the first time a nurse was not nearby. The AP said she was frightened. When the resident slumped in her wheelchair and turned colors, she

stopped the Heimlich maneuver. The AP said she had learned not to call 911 if a resident was on hospice; instead, staff called hospice or the facility nurse, which she did. The AP said no one asked her what happened and management “yelled at her” afterwards for poor communication skills. She heard staff members were retrained on the Heimlich maneuver process after she was no longer working for the facility. The AP said she was traumatized by the resident’s death.

During an interview, a nurse manager said the staffing ratio for memory care is one staff to five residents. The nurse manager said she was not immediately called about the incident. When she arrived several minutes later there were a lot of people in the room, but the AP was not there. A nurse assessed the resident’s vital signs and called EMS. The nurse manager said no one knew the resident had choked, they assumed she died of natural causes. Had they known she choked, they would have let EMS step in to provide care. The nurse manager said it did not matter whether a resident was full code or no code status, if someone was choking, the staff perform the Heimlich maneuver and call 911.

During an interview, a nurse said she was in the nursing office when the desk phone rang and whoever was on the other end sounded like they were crying or laughing strangely. She said hello a few times, but no one answered. She then received a call from the front desk to go to memory care right away but did not know what happened. The nurse said when she arrived, the AP was crying hysterically and ran out of the unit. No one went after the AP to ask what happened. The resident was slumped in her wheelchair and took two very shallow breaths which is common just before death. The nurse assessed the resident and heard one heartbeat over 15 seconds. A second nurse arrived, assessed the resident, and could not detect breathing or a heartbeat.

Review of written statements by facility and hospice staff indicated uncertainty amongst staff and EMS on the resident’s code status, when her hospice began, and whether EMS should have been contacted.

Review of records indicated the resident’s salivary gland cancer may have decreased adequate saliva production and could have increased her risk for choking. The medical examiner determined the resident’s cause of death was an accident due to food bolus asphyxia.

Review of the AP’s training records indicated she successfully completed on-line Emergency Preparedness training and passed the Heimlich maneuver competency demonstration.

The resident’s family members did not respond to multiple interview requests.

A former facility nurse who assessed the AP’s Heimlich competency did not respond to interview requests.

The investigator requested a copy of the incident camera footage but was informed the facility no longer had a copy of the footage despite documentation to the resident's family indicating the facility would preserve video and other data.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No, did not reply to multiple interview requests.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility conducted an internal investigation, retrained staff on the Heimlich maneuver and the AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23217	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/06/2023
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NAME OF PROVIDER OR SUPPLIER REGENT AT BURNSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 14500 REGENT LANE BURNSVILLE, MN 55306
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL232173882C/HL232177306M, HL232171126C/HL232175923M, and HL232177104C/ HL232179346M.</p> <p>On December 5, 2023 through December 6, 2023, 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 139 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL232173882C/HL232177306M#, tag identification 470.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 470	<p>Continued From page 1</p> <p>determining its staffing level that:</p> <ul style="list-style-type: none"> (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <ul style="list-style-type: none"> (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; <p>This MN Requirement is not met as evidenced by: Based on record review, observation and interview, the licensee failed to ensure the facility could respond promptly and effectively to individual resident emergencies when developing the licensee staffing plan. Two of two memory care residents, (R2 and R5) choked during meals when one staff was assigned in the dining room which required staff to perform the Heimlich maneuver, yet also try to contact other staff in the facility to call for emergency assistance or</p>	0 470		

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0 470	<p>Continued From page 2</p> <p>services. This had the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2 R2 lived in the memory care unit. Her diagnoses included malignant salivary gland cancer, brain cancer and dementia. R2's service agreement dated July 10, 2023, indicated she received assistance with activities of daily living. There was a delegated unlicensed personnel (ULP) task to document if R2 ate breakfast and add an unscheduled service for times she had breakfast. R2 had a regular diet with thin liquids.</p> <p>R2's progress notes dated July 10, 2023, at 12:29 p.m., indicated the hospice nurse was at facility to admit R2 to hospice. At 6:54 p.m, director of health services (DHS)-A arrived at R2's apartment after getting called to the memory care unit. R2 was seated in her wheelchair, slumped over with no audible or palpable apical pulse, no respiratory effort. Oximeter reading was 66% and falling. Emergency medical services (EMS) arrived, given report R2 was DNR (do not resuscitate), was just evaluated for hospice and would have been admitted to hospice. R2's time of death noted as 12:45 p.m.</p>	0 470		

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0 470	<p>Continued From page 3</p> <p>The licensee "Internal Investigation of Incident" dated July 10, 2023, at 12:38 p.m., indicated R2 was suspected of choking due to noted distress while eating lunch in the common area. ULP-G performed the Heimlich maneuver until R2 slumped over with little response. ULP-G then stopped performing the Heimlich. R2 was eating lunch around 12:20 p.m.; she had soup and her entree. R2 noted to be in distress at 12:35 p.m. and ULP-G started Heimlich. ULP-G also made calls to nursing and front desk at 12:38 p.m. Staff arrived in unit at 12:40 p.m. ULP-G left unit at approximately 12:42 p.m. with no report given to care team.</p> <p>Review of a licensee untitled, undated document indicated camera footage was reviewed and ULP-G performed the Heimlich maneuver until R2 became unresponsive. ULP-G called nursing and front reception to get help but she was crying and unable to communicate what was needed. Nursing staff and other staff arrived at the unit.</p> <p>During an interview on January 5, 2024 at 9:18 a.m., ULP-G said the day R2 choked was the first time the nurse was not close by. ULP-G said she was reheating R2's soup, she began eating soup and bread, when one of the residents said R2 needed help. ULP-G said she began the Heimlich, tried to move R2 in her wheelchair with her elbows and call the front desk for help. ULP-G dropped the phone twice trying to call. ULP-G said she was crying and told the front desk staff to send help. ULP-G said she was trained to do the Heimlich and did her best.</p> <p>During an interview on January, 2024 at 8:32 a.m., registered nurse (RN)-K said she was orienting a new staff member when the regular desk phone rang. It was around noon and</p>	0 470		

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0 470	<p>Continued From page 4</p> <p>whoever called was crying or laughing "weird". RN-K said hello a few times with no answer, so she hung up. She told the new staff member someone must have "butt dialed" her. RN-K said front desk staff called her and said she had to go to memory care right away but did not give a reason why. RN-K said when she arrived at the memory care unit ULP-G was on the floor crying and hysterical and then ran out of the unit.</p> <p>R5 R5 lived in the memory care unit. Her diagnoses included unspecified dementia. R5's service plan signed December 1, 2023, indicated since April 21, 2023 she received daily meal monitoring by staff to support adequate intake. R5 had a regular diet.</p> <p>A progress note dated November 28, 2023, at 1:06 p.m., indicated an emergency page went out from memory care that nursing was needed right away. R5 choked on pizza crust during lunch. ULP-J performed the Heimlich maneuver and with the second abdominal thrust the crust was expelled. EMS arrived to assess R5 and determined she did not need to go to the emergency room. The nurse assessed R5 and contacted her provider and family. Staff continued to monitor R5 as she ate dinner without incident.</p> <p>During an interview December 5, 2023, at 10:55 a.m., ULP-J said she is regularly scheduled to work in memory care and the staff ratio is one staff for five residents. ULP-J said she performed the Heimlich on R5 during the past week when she choked on a pizza crust. ULP-J said it was scary but she was trained to do the Heimlich, then called the manager.</p> <p>A policy titled Staffing, dated March 28, 2023,</p>	0 470		

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0 470	<p>Continued From page 5</p> <p>indicated the staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week and will be adequate to address the residents' scheduled and reasonable unforeseeable unscheduled needs given the physical layout of the facility.</p> <p>A policy titled Direct-Care Staffing Plan, dated April 6, 2023, indicated the adequate number of staff is determined by the scheduled services in independent and assisted living in each memory care suite at a 1:5 staffing ratio, and care suites at a staffing ratio of 6 or 7 residents.</p> <p>A policy titled Food and Nutrition Services, revised January 16, 2023, did not address mealtime staffing ratios.</p> <p>TIME PERIOD TO CORRECT: Seven (7) Days</p>	0 470		