Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL237483022M
Compliance #: HL237484936C

Date Concluded: February 6, 2024

Name, Address, and County of Licensee Investigated:
Bethany Assisted Living in Litchfield
203 North Armstrong Ave
Litchfield, MN 55355
Meeker County

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

Evaluator's Name:
Lisa Coil, 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 the facility did not provide the resident with the necessary care and health services. The resident was hospitalized with increased blood sugar and pneumonia.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility followed the resident's plan of care and the provider's orders.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager. The investigation included review of the resident record(s), and hospital records.

The resident resided in an assisted living memory care unit. The resident's diagnoses included diabetes and dementia. The resident's service plan included assistance with eating, drink, and

medication management. The resident's assessment indicated the resident had memory impairment, disorientation and was not always able to make her needs known to staff. The last two assessments prior to the resident's hospitalization indicated the resident's services did not include blood sugar checks nor insulin injections.

The progress notes indicated the night prior to being sent to the emergency room, the resident had spat up in bed. The notes indicated on the day the resident went to the emergency room she had a temperature of 99.7 and she appeared to not to be feeling well so a COVID test was completed, which was negative.

The progress notes indicated later the same evening, the resident had complained of chest pain, her speech became more difficult to understand, her eyes had an abnormal gaze, and her vital signs were abnormal. The resident was sent to the emergency room and admitted to the hospital.

The hospital record indicated the resident was admitted to the hospital with concerns of increased confusion, behavioral difficulties, and lethargy (decrease in consciousness). The record included a plan to treat diagnoses during the hospital stay which included high blood sugars with diabetic ketoacidosis (a severe complication of diabetes), sepsis (a serious condition in which the body responds improperly to an infection) related to pneumonia, and multiple abnormal electrolyte (minerals in your blood and other body fluids that carry an electric charge) .

During the resident's hospital stay, the progress notes indicated a family member called the facility and asked when her diabetic medication and blood sugar checks had been discontinued. The notes indicated the insulin was discontinued approximately three and a half years prior while the blood sugar checks were discontinued approximately two years prior.

During an interview, the case worker stated the resident became resistive to lab draws due to advancing dementia. The case worker stated she and the nurse communicated the resident's changes according to the provider's recommendations and she updated the county residential service agreement. According to the county residential service agreement, it was approximately three and a half years prior to the resident's hospitalization when lab draws were changed to as needed and approximately two years prior to the resident's hospitalization when blood sugar checks and insulin were changed to as needed.

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. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital.

Action taken by the Minnesota Department of Health:
No further action taken 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
	23748	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING IN LITCHFIELD	203 NORTH ARMSTRONG AVENUE LITCHFIELD, MN 55355

(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 2, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL237484936C/#HL237483022M. No correction orders are issued.	0 000		