Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL26844001M
Compliance #: HL26844002C

Date Concluded: December 1, 2021

Name, Address, and County of Licensee Investigated:
Trillium at Woodsedge
930 Anne Street Northwest
Bemidji, MN 56601
Beltrami County

Name, Address, and County of Housing with Services location:
Sanford Bemidji Medical Center
1300 Anne Street Northwest
Bemidji, MN 56601
Beltrami County

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

Evaluator's Name: Jill Hagen, 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):
It is alleged facility staff failed to provide the resident with her assessed and care planned toileting and safety checks. The resident fell and fractured her back.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. Several facility staff failed to provide the resident with her assessed and care planned safety checks and toileting needs. Facility staff found the resident on the bathroom floor approximately three hours after her last safety check. The resident fractured her vertebrae.

The investigation included interviews with facility staff members, including administrative staff and nursing staff. The residents medical and hospital records, staff education, staff schedules, and facility policies and procedures, including fall prevention, were reviewed.

The residents medical record indicated the resident had diagnoses that included dementia, anxiety, and osteoporosis (fragile and brittle bones). The resident made her basic needs known but staff were directed to anticipate her needs. The resident required staff assistance with dressing, grooming, bathing, assistance to eat, and every two-hour safety check alternating with every two-hour toileting assistance on the opposite hour. The resident had episodes of urinary incontinence, required staff to change her brief and provide perineal care, required one staff assistance and gait belt with a walker to ambulate, and used a wheelchair.

The resident's assessment indicated she was a high fall risk. Interventions in place to prevent falls included the resident's bed in the lowest position, chair and bed alarms, quiet alarm system that activated with motion in the room, written and verbal reminders to use the call light when needing staff assistance, and every two-hour safety check alternating with every two-hour toileting assistance.

Review of the facilities incident report indicated staff found the resident on the floor in the bathroom in a fetal position on her left side wearing her incontinent brief and a T-shirt. Initially, the resident complained of left arm pain. Staff contacted emergency services. Upon their arrival the resident complained of left hip pain. The ambulance transported the resident for an evaluation at a hospital. Interviews with staff following the fall indicated staff had not checked on the resident during their morning shift. That morning a staff called in sick for the morning shift. The staff replacement came in about one-half hour late and assisted two other residents.

Review of the resident's motion sensor alarm activation form indicated staff entered the resident's room that morning at 6:11 a.m. and not again until 9:13 a.m., over 3 hours since staff had checked on the resident or provided any assistance to the resident.

Review of the hospital record indicated the resident's diagnoses included fractures of the thoracic vertebrae (upper and middle spine) at T7 to T9, and a fracture of the lumbar vertebrae (lower spine) at L1. The record indicated the fall caused the fractures, not the resident's osteoporosis. The resident discharged from the hospital back to the facility two days later with physician orders to wear a thoracic lumbar sacral orthosis (TLSO) back brace when out of bed for the next three months.

During interview, management stated the unlicensed professional (ULP) that came in late to replace the ill call should first check on the residents that were her responsibility. Otherwise, it was a facility expectation that the two additional ULP's scheduled that morning should have split the assignment for the third staff person and check on all residents after receiving shift report. The two additional staff failed to check on the resident.

In conclusion, neglect was substantiated. Facility staff failed to follow the resident's assessed, and care planned interventions for toileting and safety checks. As a result, the resident fell and fractured her back.

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: No due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Management educated the staff reminding them of the importance of safety checks, toileting, and covering for staff when needed to ensure completion of tasks.

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Beltrami County Attorney
Bemidji City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26844	A. BUILDING: _____ B. WING _____	C 11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRILLIUM AT WOODSEDGE	**930 ANNE STREET NW BEMIDJI, MN 56601**

(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****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, the Minnesota Department of Health issued a correction order pursuant to an evaluation. 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: On November 3, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL26844002C/#HL26844001M. At the time of the evaluation, there were 23 residents receiving services under the assisted living license. The following correction order is issued for #HL26844002C/#HL26844001M, 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 observations, 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 November 3, 2021, 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.	