Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL291031780M
Compliance #: HL291039486C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:
Babbitt Carefree Living
1 Central Boulevard
Babbitt, MN, 55706
Saint Louis County

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

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide a Covid-19 test resulting in the resident's fall causing a fractured hip. The facility failed to provide care and services according to an updated service plan including bathing, escorts to meals and denture placement causing weight loss. The facility also failed to provide foot soaks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility tested the resident for Covid-19 and the results were negative. Later that day, the resident had an unwitnessed fall, was evaluated at a hospital, and tested positive for Covid-19. The cause of the fall could not be correlated with the resident testing positive for Covid-19. Records indicated the resident's weight fluctuated within three pounds. Staff provided services according to the resident's updated plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, incident reports, and related facility policy and procedures. Also, the investigator observed the facility and staff interactions with other residents.

The resident resided in an assisted living facility with a memory care unit. The resident's diagnoses included dementia and dysphagia (swallowing disorder). The resident's service plan indicated services added during the resident's stay included assistance with bathing, escorts to meals, grooming including denture care. The resident was alert to person and place, forgetful, confused, had poor decision making, and memory loss. The resident was able to understand others and able to make his needs known and understood. The resident had a history of refusing care. The resident was at risk for falls.

One day in the morning, the facility tested residents for Covid-19, and the resident's record indicated the resident's test was negative. Later the same evening, the resident had an unwitnessed fall and staff found the resident on the bathroom floor. The resident's range of motion was limited due to leg pain and possible fracture. The facility transferred the resident to the emergency room for an evaluation. The resident was diagnosed with a femur (thigh) fracture. The resident tested positive for Covid-19.

The resident's record indicated after the fall, the resident transferred to a different hospital, underwent surgery, and transferred to a facility that provided a higher level of care. While at the higher level of care, the resident had coughing episodes, was transferred back to the hospital, and diagnosed with aspiration (inhaling food, liquid, vomit) pneumonia. After the hospitalization, the resident returned to the higher level of care. The resident discharged from the higher level of care back to the facility.

The facility coordinated the resident's care with physical and occupational therapy. The facility updated the resident's medical provider on the resident's health status, implemented medication and lab orders, assisted with getting the resident a hospital bed, wheelchair, provided the resident a facility donated lift chair, and added additional services to the service plan. In addition, the facility added fall interventions which included a tabs alarm (safety alarm used for fall prevention). The resident admitted to hospice services. After admission to hospice, the resident received antibiotic treatment again for suspected aspiration pneumonia and the resident's diet changed from mechanical soft (foods that required minimal chewing) to puree diet (food that required no chewing) due to the resident's swallowing issues.

The resident's records indicated the resident's weights fluctuated within three pounds.

The resident's scheduled services record indicated the resident received bathing, grooming, denture care, and escorts to meals.

The resident's death record indicated the resident's cause of death was failure to thrive secondary to recurrent aspiration pneumonia and femur (thigh) fracture with months to onset of death.

During an interview, a kitchen staff member stated prior to the resident sustaining a fracture and a stay at a higher level of care, the resident received a regular diet. Upon return, the resident's diet was soft, and the resident received thickened liquids. The facility thickened the resident's fluids including water, juice, soups, and ensured there was nothing "chunky" in the resident's foods. The kitchen staff also ground up the resident's meat and food that was hard to chew. The resident transitioned to receiving a puree diet with thickened liquids.

During an interview, an unlicensed staff member stated she did not recall any time when the resident appeared unkempt or did not have his dentures in at mealtimes. The resident was brought out to the communal dining room.

During an interview, another unlicensed staff member stated when the resident chose to eat in his room, staff raised the resident's head of the bed while eating to assist the resident with swallowing, prevent choking, and kept the resident upright after meals. The resident also ate in the communal dining area which staff monitored.

During an interview, a nurse stated the resident tested negative for Covid-19 at the facility, fell, then tested positive at the hospital. The nurse stated the resident was "fairly" independent prior the resident's fall and fracture. Fall interventions were in place at that time. The nurse said upon return from the higher level of care, staff were aware of the resident's new diet and the resident received the diet as ordered.

During an interview, another nurse stated the resident had a decline in health status, had increased weakness, falls, was impulsive, and attempted to self-transfer without waiting for staff. The facility added interventions for fall reduction and prevention. The resident transitioned onto hospice services. While the resident transitioned towards end of life, there were occasions when the resident chose not to eat meals or receive services. The facility updated hospice services of changes and the resident received medication adjustments for comfort.

Additional concerns identified in the complaint that did not meet the level of neglect included a concern staff failed to provide foot soaks and documented foot soaks were provided. Records indicated the facility addressed foot soak service documentation concerns and reeducated staff. Staff stated these orders were eventually discontinued. There was a concern on one occasion the resident was not changed out of his clothes or assisted to bed timely. Records indicated the resident received dressing, transfer assist, and bed mobility services during shifts throughout that day. Staff stated there was one occasion when staff failed to assist the resident to bed timely however, the resident was resting in his wheelchair comfortably. Staff on the next shift assisted the resident to bed.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility transferred the resident to the emergency after the resident fell. Upon return, the facility added fall interventions and updated the resident’s providers on changes in health status.

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
	29103	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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 June 3, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL291039486C/#HL291031780M. No correction orders are issued.	0 000		