DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294468562M
Compliance #: HL294465702C

Date Concluded: March 21, 2025

Name, Address, and County of Licensee Investigated:
Heritage Pointe Senior Living
207 North 4th Street
Marshall, MN 56258
Lyon County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 facility staff failed to follow the care plan resulting in the resident falling and being hospitalized with a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. An unlicensed facility staff member did not use a gait belt at the time of the fall; however, neglect occurred following the fall when multiple unlicensed staff failed to notify a registered nurse (RN) when the resident began to complain of severe leg pain and a decline in mobility which delayed medical intervention and pain management. The resident was not transferred to the emergency room for 15 hours after the initial complaints of pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included vascular dementia, congestive heart failure, and atrial fibrillation. The resident also received hospice services. The resident's service plan included assistance with medication management, toileting assistance, dressing, grooming, and oxygen management. Under the notes/alerts section of the service plan, it was indicated that the resident required one assist for transfers, and a wheelchair for mobility, but transfer assistance was not included as a service the resident required. The service plan did not indicate how the resident should be assisted with walking. The resident's assessment indicated the resident resided required assist of one with a gait belt and walker for transfers and ambulation. The assessment indicated the resident was cognitively impaired and had no history of recent falls or pain.

Facility documentation indicated the resident was transferred to the bathroom, lost her balance and was lowered to the floor around 8:40 p.m. The unlicensed staff did not use a gait belt prior to the fall. The unlicensed staff contacted the hospice nurse and were directed to use a mechanical lift to transfer the resident off the floor since the resident did not hit her head and was not complaining of pain at that time. During the transfer, the resident began to complain of pain and continued to complain of pain while the staff turned and repositioned the resident in bed. The night staff indicated the resident was in pain during the night and would yell in pain during turning and repositioning. Facility documentation did not include notification of a nurse after the resident began to complain of pain. Documentation also did not indicate that as-needed pain medications or other interventions were administered despite the resident's continued complaints of pain. The resident's family was not notified of the fall or ongoing complaints of pain until the hospice nurse called around 11:00 a.m. the next day.

Emergency room (ER) and hospital records indicated the resident presented to the emergency room after a fall last night with complaints of left leg pain. Hospital diagnoses included left hip fracture, severe sepsis secondary to a urinary tract infection, and hypokalemia (low potassium). The resident was deemed a poor surgical candidate and family agreed to comfort care measures. During the hospital stay, the resident received intravenous pain medications and antibiotics. The resident discharged back to the facility four days later with orders for antibiotics and pain medication.

During investigative interviews, multiple staff members stated the resident began to complain of pain while being transferred off the floor with a mechanical lift following the fall. The resident continued to complain of pain while staff were assisting the resident with turning and repositioning. Staff stated the resident would scream, holler, or yell in pain when they moved or touched her. Multiple unlicensed staff members stated they did not contact a nurse because they thought hospice was going to come the next morning.

During an interview, the licensed practical nurse (LPN) stated she was informed the next morning around 7:00 a.m. that the resident fell and had discomfort. The LPN stated she contacted the hospice nurse and the resident's family member. The LPN did not contact the facility registered nurse (RN) to conduct an assessment prior to arrival of the hospice nurse.

During an interview, the facility RN stated she was not contacted after the resident complained of pain. Facility staff should have contacted the RN for instruction and a RN should have come in to assess the resident following the fall. The RN confirmed there had not been facility wide education regarding notification of a RN following complaints of pain or a change in condition following the incident.

During an interview, the resident's family stated they were not contacted by anyone from the facility about the resident's fall and severe pain until the next day around 11:00 a.m. when the hospice nurse contacted them. The resident's family stated if they would have known the resident was in pain, they would have had the resident brought to the ER for pain management. The resident's family stated the resident's quality of life has greatly decreased since the fall as she is not able to get out of bed due to the hip fracture and pain.

In conclusion, the Minnesota Department of Health determined 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 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, due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility initiated an investigation of the incident.

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
Lyon County Attorney
Marshall City Attorney
Marshall Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29446	A. BUILDING: ___ B. WING ___	C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINTE SENIOR LIVING	**207 NORTH 4TH STREET MARSHALL, MN 56258**

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL294465702C/#HL294468562M On January 28, 2025, 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 56 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for ##HL294465702C/#HL294468562M tag identification 2310, 2360.	0 000	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. 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	

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

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide care in accordance with accepted healthcare standards for one of one resident (R1) reviewed. The licensee assessed R1's need of assistance with transferring and ambulation, however, R1's service plan did not include detailed information to describe how staff should provide R1's assistance. In addition, multiple staff failed to notify a registered nurse (RN) after R1 had severe pain following the fall which delayed medical intervention and pain management. R1 was hospitalized with a hip fracture. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	02310	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. 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.	

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02310	Continued From page 2 R1 was admitted to the licensee's assisted living facility on August 12, 2020. R1's diagnoses included vascular dementia, congestive heart failure, and atrial fibrillation. R1's assessment dated October 16, 2024, indicated R1 resided in the memory care unit and required assist of one staff member with a gait belt and walker for transfers and ambulation. The assessment indicated R1 was cognitively impaired and had not fallen recently and did not have pain or a history of pain. An undated, unsigned, typed, paper care plan indicated R1 required assistance with transferring and ambulation and a gait belt. It is unknown when this document was updated. R1's service plan June 25, 2024, indicated R1 received daily assistance with medication management, toileting assistance, dressing, grooming, and oxygen management. Under the notes/alerts section of the service plan indicated R1 required a gait belt with one assist for transfers, and a wheelchair for mobility, but transfers were not included as a service R1 required. The service plan did not indicate how R1 should be assisted with ambulation. R1's December 2024, service delivery record did not indicate R1 required assistance with transfers or ambulation. R1's January 2025, service delivery record indicated R1 did not require assistance with transfers until January 13, 2025. R1's progress notes dated January 9, 2025, indicated on January 8, 2025, at 8:40 p.m., R1	02310	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.	

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02310	Continued From page 3	02310		

complained her head hurt and fell to the floor in the bathroom. Staff contacted the hospice nurse and were instructed to transfer the resident to the bed with a hoyer lift. While being transferred, R1 began to complain of left hip pain. The progress notes did not indicate unlicensed staff notified a registered nurse (RN) that R1 complained of pain.

Hospice notes dated January 8, 2025, at 9:04 p.m., indicated an unlicensed staff contacted hospice reporting R1 was lowered to the ground with staff present and R1 did not hit their head. R1 complained of a headache and could move arms and legs. Staff were directed to assist R1 with the hoyer lift and instructed staff to administer Tylenol. The note did not indicate R1 complained of pain.

Hospice notes dated January 9, 2025, at 12:00 p.m., indicated R1 fell in the bathroom the evening prior and when staff attempted to assist R1 with morning cares, R1 was screaming out in pain and would not let them touch her. The hospice nurse attempted to move R1's leg and R1 yelled out when the nurse attempted to move her leg. Family wanted R1 to been seen in the emergency room despite receiving hospice services.

R1's medical record lacked documentation that a RN was contacted after R1 began complaining of pain.

R1's emergency room (ER) and hospital records dated January 9, 2025, at 12:07 p.m., indicated R1 presented to the ER after a fall last night with multiple pain complaints of pain on the left side, left hip and thigh region. Family requested hospice be discontinued to perform testing and

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02310	Continued From page 4	02310		

evaluation to see if anything required treatment. Hospital diagnoses included closed fracture of the left hip, severe sepsis (systemic infection) secondary to a urinary tract infection, and hypokalemia (low potassium). R1 was deemed a poor surgical candidate and family agreed to comfort care measures. During the hospital stay, R1 received intravenous pain medications and antibiotics. On January 13, 2025, R1 discharged back to the licensee.

The licensee's interviews with the night shift staff dated February 5, 2025, indicated on January 8, 2025, to January 9, 2025, when they would attempt to move R1 she moaned or yelled in pain. The night staff did not contact a RN because they were told hospice was coming in the morning and knew they could not call 911 since the resident was on hospice.

The licensee's initial mitigation plan, dated January 9, 2025, did not include identify concerns regarding R1's pain, change in condition, or notification of a RN.

On January 28, 2025, at 3:35 p.m., unlicensed personnel (ULP)-A stated another ULP called and requested assistance after R1 fell. R1 was laying on the floor in the bathroom with her head towards the toilet and laying on her left side with both of her hands under her head. ULP-A and two other ULP's assisted R1 to bed using the hoyer lift after speaking to a hospice nurse. ULP-A said R1 was "screaming a bit," while the ULP undressed and repositioned her. R1 stated it hurt but couldn't tell staff where it hurt. ULP-A stated she did not call a nurse after R1 complained of pain.

On January 28, 2025, at 4:14 p.m., ULP-B stated

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she assisted R1 with evening cares. R1 said her head hurt and fell while walking her to the bathroom. ULP-B stated R1 fell forward and fell onto her left side. ULP-B stated she was walking next to R1 and did not use a gait belt. ULP-B stated she was a new employee and during orientation no other staff used a gait belt when transferring R1. ULP-B stated she tried to slow down her fall by trying to put her arms under R1's armpits. Hospice informed staff to monitor R1 and since R1 did not complain of pain while on the floor, they were directed to transfer R1 with the hoyer lift to bed. ULP-B stated R1 started having pain while they turned and repositioned her in bed while changing her clothes. Anytime staff touched or moved R1 she would yell or holler. ULP-B stated she did not contact a RN after R1 complained of pain.

On February 11, 2025, at 11:10 a.m., ULP-C stated another ULP came to get her after R1's fall as she was concerned R1 was not lowered to the floor and fell. ULP-C stated R1 was lying on the bathroom floor on her left side without a gait belt on. ULP-C stated after the fall she contacted the facility RN to voice her concerns about how ULP-A initially described the fall and how R1 was found on the floor. The facility RN stated she would review the incident the next morning. ULP-C stated while the other ULP's were assisting R1 with transferring, and changing clothes she could hear R1 screaming in pain from the office. ULP-C said she heard R1 say things like, "stop doing that, my hip, my leg, my shoulder." ULP-C did not contact a RN after R1 complained of pain.

On February 11, 2025, at 12:30 p.m., RN-D stated resident services were listed on a paper copy and electronically. RN-D stated the most

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02310	Continued From page 6 updated version of resident services were electronic. RN-D confirmed R1's transfer status was in the notes section but did not include how staff should assist R1 with ambulation. RN-D verified the service plan did not include a detailed description of R1's transferring and ambulation needs. RN-D said an ULP called her on January 8, 2025, after the fall that evening. The ULP was concerned as it did not seem R1 was lowered to the floor, due to the way R1 was positioned. RN-D stated the staff working that evening should have contacted hospice and the facility triage nurse instead of only hospice. RN-D reported a nurse was not contacted after R1 started complaining of pain. ULP should have contacted a RN for instruction. RN-D would have instructed ULP's to lower R1 back to the floor and call the triage nurse, or hospice nurse. RN-D stated hospice should have come in to assess the resident. RN-D confirmed there had not been facility wide education regarding following the resident's service plan or change in condition related to pain following the incident. On February 12, 2024, at 9:05 a.m., licensed practical nurse (LPN)-E stated on January 9, 2025, at 7:00 a.m. night staff informed her R1 fell the evening prior and had discomfort. At that time, LPN-E checked on R1 and she was sleeping. At 8:15 a.m., R1 complained of pain from her hip to her foot. LPN-E stated she contacted hospice and R1's family member. LPN-E stated the hospice nurse arrived around 10:30 a.m. and R1 was sent to the ER around 11:00 a.m. LPN-E stated a facility RN did not assess R1 that morning. LPN-E stated R1 had Tylenol 500 milligrams (mg) scheduled every 4 hours, but did not receive any other as-needed medications throughout the night or the next morning.	02310		

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02310	Continued From page 7 On February 12, 2025, at 1:00 p.m., family member (FM)-F and FM-G stated they were not contacted about R1's fall until around 11:00 a.m. the following day by the hospice nurse and were not contacted by facility staff prior to that. They were notified R1 was having severe pain following a fall last evening. They made the decision to send R1 to the ER for evaluation and treatment. FM-F and FM-G stated if they were informed R1 had a fall and was in severe pain they would have had R1 sent to the emergency room right away. FM-G stated it broke her heart that R1 was in pain and they were not aware so they could have sent her to the hospital sooner. The licensee's Adverse Event policy dated February 2021, indicated the licensee should perform a root cause analysis process to identify the specific/source, root cause or causal factor of the problem. Initiate a mitigation plan to address the adverse event/potential adverse event and minimize similar events for all residents and use information learned by sharing results and plan with the quality assurance performance improvement committee for continued monitoring. The licensee's RN after hours policy dated March 2024, indicated in the event of a significant change in condition, resident fall, or other emergency situation, the on-call RN will: determine severity and client's wishes, recommendations may include emergency services, emergency room, upper management, increasing supervision, recheck vital signs, etc. For all clients on hospice, call hospice before recommending any ER visits and determine if a hospice visit is needed. The RN after hours will notify families/responsibility party as part of the process and to be able to answer any questions.	02310		

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02310	Continued From page 8 No further information provided. TIME PERIOD TO CORRECT: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment 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: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	