Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL29508014M
Compliance #: HL29508015C

Date Concluded: March 24, 2021

Name, Address, and County of Licensee Investigated:
All Saints Senior Living
1880 Independence Drive
Shakopee, MN 55379
Scott County

Name, Address, and County of Housing with Services Investigated:
All Saints Senior Living
1880 Independence Drive
Shakopee, MN 55379
Scott County

Facility Type: Home Care Provider

Investigator's Name:
Erin Johnson-Crosby, 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: The client was neglected when facility staff failed to conduct an assessment and notify the provider after a fall when facial bruising, swelling and a change in condition occurred.

Investigative Findings and Conclusion:
Abuse was substantiated. The facility was responsible for the maltreatment. Facility staff failed to notify the client's provider after the client experienced changes in his health condition after a fall. At the time of the fall, the client was prescribed blood thinning medication. The client experienced bruising, facial swelling, and cognitive changes, which led to another fall requiring the client's hospitalization. The client was later diagnosed with a subdural hematoma (brain bleed).

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. Facility and hospital documents were reviewed.

The client's diagnoses included macular degeneration (loss of vision), atrial fibrillation, and coronary artery disease. The client's service agreement identified the client required staff assistance with medication administration, bathing and showering and received daily safety checks.

Review of the client's last nursing assessment identified the client was able to identify how many pills he received in the morning and at night. The client transferred independently and walked with a four-wheeled walker.

Review of the facility incident report identified the client had a history of falls. At one point, the client was found on the floor next to his bed; he stated he slid off his bed. There were no apparent injuries, and the provider was notified. However, a bruise later formed to the left side of the client's face and medical monitoring was added to the client's care plan. The client's pupils were round, equal and reactive to light. The client reported some facial tenderness after the fall, and the client's son was notified. The incident report did not include communication to the provider regarding the facial bruising or that the client received Xarelto (a blood thinning medication). The incident report also did not include characteristics of the bruising.

Review of the client's service checkoff list identified facility staff should monitor the client's bruising to the left side of his face and document the results of the monitoring in the client's progress notes every day until the bruising healed. The client's progress notes did not include any documentation of the bruise for the third and fourth day after the fall, but the service checkoff monitoring was signed off as completed.

Review of the client's medication administration record (MAR) identified the client received Xarelto 20 milligrams (mg) daily. The adverse reactions listed included hemorrhage (severe bleeding). The client received as-needed (PRN) acetaminophen for pain the day after the fall.

Review of the client's progress notes identified the day after the fall, bruising was noted around the client's left eye and the left side of his face. The client reported tenderness to the area. The progress notes did not include characteristics of the bruise or notification to the provider.

Two days after the fall, the client left the stopper closed in his bathroom sink with the water running, which caused flooding to his apartment. The client was moved to memory care due to the water damage to his apartment. The client stated, "I'll take the blame; they've been out to get me for six months." At that time, bruising was noted around the left side of client's mouth, down his left chin area, and both arms. Minimal swelling was noted just below the client's left eye. The client stated that he hit his left eye area when he fell. The client denied pain or headache. The nursing staff notified the provider and requested laboratory tests and therapy for cognitive testing. The nursing staff did not communicate to the provider the client was on Xarelto (which can cause internal bleeding) or swelling to the client's left eye.

Three days after the client's fall, the client appeared confused and disoriented at supper. He spilled his soup and water on his table and then returned to his normal baseline cognition.

Four days after the client's fall, staff noted the client was sleeping with his lunch on his table untouched. That evening, the client did not eat supper and stated he was not hungry and wanted to go to bed. The client was already in bed when he was checked on during supper time.

The next day, the client was found lying on the floor with new bruising to the left side of his face. The client was reaching out in the air and not responding appropriately. The client could not answer questions and was responding with moans or slurred speech. The client was holding his head and complaining of pain. The client was sent to the emergency department and diagnosed with a subdural hematoma (brain bleed).

Review of a photograph taken by the client's family member two days after the fall showed moderate to dark purple bruising to the left half of the client's face from his chin up to his nose. The client's left eye swelling was also visible in the photograph.

The client's hospital records identified the client was admitted for management of a subdural hematoma. The client was improving until he fell in the hospital, which caused worsening of the subdural hematoma. The client died the day after his fall in the hospital.

The client's death record identified the cause of death was from the subdural hematoma and falls.

When interviewed, the client's family member said they visited the client two days after his initial fall and noticed bruising to the left side of the client's face and a swollen left eye. During the visit, the family member said the client was rubbing his head complaining of a headache; he was not talking clearly and seemed to be out of it. The family member said the client was acting differently than he had a week earlier. The family member said there was a nurse outside on her break, and he spoke to her about his concerns. The family member did not remember what nurse he spoke to during the visit. The family member took a picture of the client during the visit. The picture showed notable bruising to the left side of the client's face and swelling around his left eye.

When interviewed, licensed practical nurse (LPN)#1 said if a client is prescribed a blood thinner medication, the provider should be notified if facial bruising is identified after a fall. LPN#1 said she noticed the bruising to the client's face the day after his fall. LPN#1 said she would like to think she contacted the provider and completed a neurological assessment; however, there was no documentation in the client's record of provider communication or a client assessment.

When interviewed, LPN#2 said if a client is on Xarelto or any blood thinner, we (staff) take extra precautions because of the high risk for bleeding. LPN#2 said a neurological assessment would be initiated for 24 hours after the fall. LPN#2 said she remembered the client lived in assisted living then quickly declined and moved to memory care. LPN#2 said she reported the fall to the

oncoming nurse regarding the client's confusion and drowsiness but did not contact the provider or her supervisor because it was not a concerning situation. LPN#2 also said when the client moved to memory care, he needed assistance with transfers and walking because one of his eyes was really swollen.

When interviewed, LPN#3 said, at one point, she was notified by a home health aide the client was on the floor. When she arrived, she said she observed the client sitting on the floor next to the bed; the client said he did not hit his head. LPN#3 said there were no injuries noted at the time of the fall. LPN#3 completed vital signs and a neurological check and reported this to the oncoming nurse. LPN#3 said neurological and mini-mental assessments are completed for 24 hours after all unwitnessed falls.

When interviewed, the registered nurse (RN) said the client should have received neurological assessments for 24 hours after the facial bruising was noted, and the provider should have been notified of the client's changes in cognition. The RN said the client had not exhibited behaviors, like flooding his apartment, before. She stated she was also not aware of the client's confusion or drowsiness. She stated she would expect staff to communicate changes in condition to her and the provider.

When interviewed, the Executive Director said the (nursing) supervisor and provider should have been notified about the client's changes in condition.

The client's provider was unable to be interviewed during this investigation.

In conclusion, neglect was substantiated against the facility.

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. The client is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
Staff training related to unwitnessed falls and bruising was reviewed at morning staff meetings and team huddles. A mitigation plan was also implemented for the second fall.

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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.
cc:

The Office of Ombudsman for Long-Term Care
County Attorney for Scott County
City Attorney for Shakopee, MN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29508	A. BUILDING: _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEALWOOD MANAGEMENT LLC	1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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 March 11, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL29508014M/HL29508015C. The following correction order is issued for complaint #HL29508014M/HL29508015C, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested?for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 325		

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0 325	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of three clients (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On March 24, 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 an incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		