

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304257165M
Compliance #: HL304253526C

Date Concluded: February 9, 2024

Name, Address, and County of Licensee

Investigated:

Pathstone Crossing
710 Mound Ave
Mankato, MN 56001
Blue Earth County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator #1 (AP #1) and the alleged perpetrator #2 (AP #2) neglected two residents by leaving them on the floor throughout the entire night after discovering them in that condition.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. AP #1 and AP #2 were responsible for the maltreatment. While working the night shift, they found two residents on the floor during their rounds. The two APs did not assist either resident up off the floor, nor did they inform the nurse of the situation. The residents remained on the floor until morning when the dayshift caregivers were informed the residents were on the floor.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the residents' records, death record, hospital records, facility incident reports, personnel files and staff schedules. Also,

the investigation included an onsite visit, observations, and interactions between residents and facility staff.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses include dementia. Resident #1's service plan included assistance with hygiene, dressing, and toileting. The service plan also included repositioning schedule and safety checks every two hours on the night shift.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses include dementia. Resident #2's service plan included assistance hygiene, dressing, and toileting. The service plan also included repositioning schedule every two hours on the night shift.

During an interview, an unlicensed caregiver said she received a report from AP #1 and AP #2 the next morning. They informed her two residents had fallen on the floor, and when she asked if resident #1 had been helped off the floor, they said no, both residents were still on the floor. The unlicensed caregiver stated AP #2 said she changed resident #1's incontinence pad while he was lying face down on the floor. The unlicensed caregiver saw resident #1 lying face down on the floor appearing uncomfortable and there was urine on the floor. AP #2 told the unlicensed caregiver resident #1 was sleeping on the floor. The unlicensed caregiver stated that AP#1 and AP#2 started arguing and yelling at each other when they were asked why they did not assist the residents. The unlicensed caregiver confirmed that both resident #1 and resident #2 were left lying on the floor until morning.

During an interview, a management staff member stated both residents had a service schedule every two hours at night. AP #1 and AP #2 reported to the day shift, two residents were on the floor. The day shift then checked on the residents, the nurse conducted assessments, and the two residents were assisted up off the floor. Neither resident had a history of sleeping on the floor. The manager stated the facility conducted an investigation and both APs were placed on leave. The manger stated both APs claimed they thought the other AP would assist the residents. The facility terminated both AP's employment.

During an interview, AP #1 stated she had just completed training and worked that night with AP #2. She explained she was on modified duty due to a foot injury and was restricted from heavy lifting. In the previous week, resident #1 fall, and staff members from another unit came to assist getting him up. On the night in question, AP #2 asked for help when she found resident #1 on the floor. AP #1 stated she went in the room and saw AP#2 changing resident #1's incontinence pad. AP#2 left to get the Hoyer lift and AP #1 waited but AP#2 did not return. AP#1 stated she found AP#2 at the nursing stating and AP#2 said she already assisted resident #1, so AP#1 thought it was taken care of. AP#1 did not recall the time they found resident #1 on the floor.

During an interview, AP #2 stated she worked with AP #1 that night. On the second check round, they found resident #1 and #2 on the floor in their respective rooms and attempted to

assist them. AP#2 stated both residents did not look like they fell and were not in awkward or uncomfortable positions. Both residents appeared as though had purposely positioned themselves on the floor. AP #1 and AP #2 decided to check back on them later. AP#2 stated AP#1 told her she would get the residents off the floor, and AP#2 offered to assist if needed since AP#1 was had an injured ankle. AP #1 and AP #2 attempted to lift resident #1 off the floor, but they were unable to do so. AP #2 stated they found both residents on the floor around 2 a.m. AP #2 did not call the nurse because she thought it might be common for residents to sleep on the floor.

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, resident #1 was not interviewable due to cognitive loss and resident #2 was deceased.

Family/Responsible Party interviewed: No, attempts to reach families were unsuccessful

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility investigated the incident and terminated AP #1 and AP #2.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the

Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Mankato County Attorney

Mankato City Attorney

Mankato Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30425	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/08/2024
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NAME OF PROVIDER OR SUPPLIER PATHSTONE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001
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0 000	<p>Initial Comments</p> <p>On January 8, 2023, the Minnesota Department of Health initiated an investigation of complaint HL304258104M HL304255160C, HL304258124M HL304255186C and HL304257165M HL304253526C .</p> <p>The following correction orders are issued</p> <p>For HL304258104M HL304255160C and HL304257165M HL304253526C: correction order identification 2360 .</p> <p>For HL304258104M HL304255160C and HL304258124M HL304255186C: correction order identification 1480.</p>	0 000	<p>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 License 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 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 surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p>	
01480 SS=G	<p>144G.63 Subd. 3 Orientation to resident</p> <p>Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.</p> <p>This MN Requirement is not met as evidenced</p>	01480		

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

Minnesota Department of Health

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01480	<p>Continued From page 1</p> <p>by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to the residents (R3 and R4) and the services to be provided for an agency unlicensed personnel (ULP-A) with records reviewed. Additionally, the facility failed to ensure ULP-A had the pager or pager log-in to monitor the call light system on the assisted living unit she was floated on to work which led to delayed reponse to call lights. R3 activated his call light after a fall with bleeding but when no response occurred R3 called 911 himself for transfer to the hospital.</p> <p>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).</p> <p>The findings include:</p> <p>R3 admitted on August 16, 2019, with medical diagnosis of diabetes and congestive heart failure.</p> <p>R3's service plan dated August 26, 2023, indicated R3 required assistance with repositioning scheduled for 11 p.m. and toilet reminders at various intervals: 12 a.m., 2 a.m., 4 a.m., 5:50 a.m., and 10 p.m. Additionally, the resident's assessment dated August 24, 2023, indicated blisters on the right lower leg and the requirement for assistance from one person during transfers.</p>	01480		

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01480	<p>Continued From page 2</p> <p>R3's progress note dated August 27, 2023, at 7:01 a.m., indicated R3 was sent to the Emergency room (ER) and there was blood on the floor in his room.</p> <p>R3's incident report dated August 31, 2023, at 6:49 p.m., indicated R3 push his pendent and no one responded, R3 had to call 911 himself due to bleeding from his lower leg. Emergency medical technician (EMT) arrived and waited at the door for 20 min. R3 was sent ER for assistance with the bleeding.</p> <p>R4's admitted on September 9, 2022, with medical diagnosis of diabetes.</p> <p>R4's service plan dated August 26, 2023, indicated R4 required safety check daily at 1 a.m., 3 a.m., 5 a.m. and 7 a.m.</p> <p>R4's progress note dated August 27, 2023, at 8:41 a.m., indicated R4 had an unwitnessed fall and was found at 7:30 a.m. According to R4, he had been on the floor since 10:30 p.m. last night. R4 had no injury besides weakness of his right side and redness both ears and hands.</p> <p>ULP-A was an agency staff and started working for the facility on August 3, 2023. ULP-A worked the night shift of August 27, 2023, where R3 and R4 lived.</p> <p>A review of ULP-A 's employee record did not identify documentation ULP-A received resident-specific orientation.</p> <p>During the interview on January 16, 2024, at 10:01 a.m., ULP-A explained she was an agency staff member originally assigned to work in the</p>	01480		

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01480	<p>Continued From page 3</p> <p>memory care unit. However, upon arriving at work, she was asked to work in the assisted living unit. She agreed to this change under the condition a staff member would show her around and provide instructions. Unfortunately, the promised staff member never returned to fulfill this commitment. ULP-A did not have a phone or pager, leaving her unsure about what to do. She acknowledged she learned of R3's fall only after emergency medical assistance arrived at the door. After R3 was transferred to the hospital, CD provided her with a pager to respond to call lights. ULP-A stated she did not have a care sheet to describe the residents' scheduled services, so she did not know what those were. She stated she provided care to residents who activated their call lights, as she was unaware of other scheduled services.</p> <p>During the interview on January 16, 2024, at 10:56 a.m., the clinical director (CD) stated it was ULP-A's third time working for the facility and her first time in the assisted living unit. According to the CD, ULP-A had not logged into the system, and she did not have a pager with her until he came in at 2 a.m. The CD emphasized she was unprepared and merely present. He also mentioned ULP-A did not respond to the call light when R3 injured his leg. R3 had to wait for an hour and called 911 himself. Additionally, the CD noted ULP-A did not check on R4 during his scheduled safety check every two hours. R4 reported falling at 10:30 p.m. and was found on the floor in the morning by another staff.</p> <p>According to the email correspondence, dated January 18, 2024, CD stated ULP-A did not log in, and another staff member working with her signed-off on all the services for the previous two shifts she worked in the memory care unit.</p>	01480		

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01480	Continued From page 4 The licensee's policy titled Assisted Living Orientation-ULP staff, dated August 1, 2021, indicated under section 6: In addition to training all staff receive, ULPs who are a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: Person-centered care and service delivery including how they apply to direct support services and Documentation requirements for services provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01480		
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 three of four residents reviewed (R1, R2 and R3) was free from maltreatment. Findings include: Regarding HL304257165M involving R1 and R2 the Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and two individuals were 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.	

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02360	Continued From page 5 Regarding HL304258104M involving R3 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		