Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304258124M
Compliance #: HL304255186C

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: Inconclusive

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 (AP) neglected the resident by not conducting regular checks throughout the night shift, despite the resident having a scheduled safety check every two hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The investigation found contradictory accounts and a lack of evidence to demonstrate neglect occurred. While it was true the AP did not conduct the checks according to the resident's service schedule, it was the first time the AP, who was from a staffing agency, worked on that unit and initially she did not have the call light pager nor a guide to the scheduled services. Mid-way through the shift, the AP received the call light pager, but it was unclear whether the facility provided her with the resident's scheduled services. Caregivers from the next shift found the resident after an unwitnessed fall. The resident stated he had his call light for hours while he laid on the floor,

but the call light had not been activated nor was the resident's physical condition consistent with laying on the floor for an extended period.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigation included review of resident's records, the AP's personnel record, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living unit. The resident's diagnoses include diabetes. The resident's service plan included safety checks and offers to toilet overnight every two hours. The medical record indicated he had a history of falls.

The progress notes indicated the resident had an unwitnessed fall overnight and was found at 6 a.m. by caregivers beginning the day shift when they went to check on him. The resident said he had put on his call light when he fell at 10:30 p.m. the night before. The resident had no injuries and was otherwise doing well so the nurse instructed the caregivers to monitor the resident.

A review of the call light log indicated the resident's call light had not been activated during the night shift. The staff members who found him were unable to confirm his call light had been activated at any point.

Later that same day at lunch, the caregivers checked on him again and found he could not put weight on his right arm and had difficulty walking so he was transferred to the hospital for further evaluation.

The resident's hospital records indicated no acute injuries were identified. The hospital records specially indicated the resident had "no rhabdomyolysis" (a condition that occurs if muscles are damaged after an injury such as prolonged lying on a floor). The resident was diagnosed with a urinary tract infection, received antibiotics, and received an order for physical therapy.

During an interview, the AP confirmed she was from an agency and, while she had worked in the facility memory care unit before, this was her first time working in the assisted living unit at the facility, with which she was not familiar. The AP explained she was initially scheduled to work in the memory care, but the facility floated her out to work in the assisted living unit. The AP stated a facility employee had promised to show her around the unit and provide her with a pager but never did. As a result, she did not have the pager and was unaware of the necessary procedures. The AP stated about halfway through the night shift a member of management arrived and gave her the pager only, but no care sheet was provided. At this point she began to answer call lights and assisting residents. She stated she did not know which residents required safety checks, so she focused on responding to call lights

During an interview, a member of management stated it was the APs third time working for the facility, but the first time in the assisted living unit. The manager stated he came to the facility

at 2:00 a.m.., helped in her log into the pager system, gave her a pager, printed a service schedule, and discussed it with her. The manager stated that until he arrived the AP had not logged into the pager system, nor did she have a pager during the incident. The manager stated the AP was present but unprepared. He stated he stayed at the facility until sometime between 4-5 a.m. and thought the AP understood what to do and the charting system. The manager stated the resident had safety checks every two hours throughout the night shift, and the AP did not perform any of them. The manager stated the resident claimed to have been on the floor since 10:30 p.m. however, the call light log did not show the resident's call light activated as he claimed but caregivers from the day shift found the resident on the floor during their check. The manager stated he entered the building at 2 a.m., logged the AP in the system, provided her with the pager, printed out the service schedule, and handed it to her. He stated he expected to know what to do, as she had the necessary tools. She knew where to find him if she needed help as she asked him to help her a resident. He stated he left between 4-5 a.m.

During an interview, a nurse said the resident was unsteady and ambulated with a walker. She stated he fell that night but did not sustain any injuries. However, he was admitted to the hospital for further evaluation later that same day. The nurse confirmed the resident had a safety check every two hours overnight. She explained the facility had a system outlining all the care tasks the staff was supposed to perform, and they needed to check off all the cares provided.

The AP and the manager gave conflicting accounts regarding whether she was given a guide to the scheduled cares for the second half of the shift.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, attempts were not successful
Family/Responsible Party interviewed: No, attempts were not successful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP was no longer working for the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30425	A. BUILDING: _____ B. WING _____	C 01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHSTONE CROSSING	718 MOUND AVENUE MANKATO, MN 56001

(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 January 8, 2023, the Minnesota Department of Health initiated an investigation of complaint HL304258104M HL304255160C, HL304258124M HL304255186C and HL304257165M HL304253526C . The following correction orders are issued For HL304258104M HL304255160C and HL304257165M HL304253526C: correction order identification 2360 . For HL304258104M HL304255160C and HL304258124M HL304255186C: correction order identification 1480.	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 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. 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.	
01480 SS=G	144G.63 Subd. 3 Orientation to resident 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. This MN Requirement is not met as evidenced	01480		

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01480	Continued From page 1 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. 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: R3 admitted on August 16, 2019, with medical diagnosis of diabetes and congestive heart failure. 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.	01480		

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01480	Continued From page 2 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. 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. R4's admitted on September 9, 2022, with medical diagnosis of diabetes. 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. 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. 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. A review of ULP-A 's employee record did not identify documentation ULP-A received resident-specific orientation. 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	01480		

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01480	Continued From page 3 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. 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. 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.	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		