*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL304506625M
**Compliance #:** HL304502387C

**Date Concluded:** November 21, 2023

**Name, Address, and County of Licensee Investigated:**
Colony Court
200 22nd AVE
Waseca, MN
Waseca County

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

**Evaluator's Name:** Lena Gangestad, RN
Special Investigator

Finding: **Substantiated, individual responsibility**

**Nature of the 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 a resident when she failed to do a well check on the resident at the end of her shift as required by the care plan.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was substantiated. The AP, who was an unlicensed caregiver, was responsible for the maltreatment. She documented she completed a well check near the end of her shift meanwhile the resident had left his apartment, exited the building, fallen outside, and required hospitalization when he was found by staff members arriving for the night shift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, the AP's personnel record, facility's policies and procedures, incident reports, and the resident's external medical record. The

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

The resident resided in an assisted living building. The resident's diagnoses include macular degeneration and kidney disease. The resident's care plan included needed supervision or standby assist for mobility, utilizing a wheeled walker or wheelchair as needed.

The facility incident report indicated the resident was found lying on the ground of the outside the facility at 10:55 p.m. when an unlicensed caregiver pulled in the parking lot to work the night shift. The same document indicated the resident was found lying on the ground on his back. The resident could not state what happened but complain of being "freezing" cold. The unlicensed caregiver called 911 and updated the on-call facility nurse.

Two days prior to the incident report indicated the resident fell and sustained a skin tear. The same document indicated the resident had safety well checks at night.

The resident's medical record indicated the facility added an additional well check near the end of the end of the evening shift at 22:00 (10:00 p.m.) the next day as part of his routine. The next scheduled well check was scheduled for 12:00 midnight during the night shift. The same document indicated the AP documented completed the scheduled well check one day prior to the incident.

On the same day as the incident the facility schedule indicated the AP worked from 2:30 p.m. to 11:00 p.m. on the evening shift.

The resident's medical record indicated the AP documented she provided the night cares, grooming assistant and escort the resident to meal at 9:40 p.m. On the same night as the incident the resident's medical record indicated the AP documented completing the well check at approximately 10:30 p.m. near the end of the evening shift.

During an interview, a management staff member stated she had reviewed surveillance footage from the evening of the incident. The management staff member stated the footage showed the resident walking out of his apartment at 9:40 p.m. She commented that it was not unusual for the resident to go outside, it was unusual for him to do so in the evening. The same video did not show the AP go to the resident's room for the last well check of the evening shift. The manager stated the video itself was no longer available, but she had reviewed it.

During an interview, the registered nurse stated she received a call from an oncoming staff member at 11 p.m. that the resident had been found outside on his back. The nurse stated the resident had a history of falls and checks were one of the interventions used to address this.

During an interview, a staff member #1 stated all the staff knew the resident well checks. She said she worked on the night the incident happened. She stated she saw the AP got into her car and left without looking back when she knew the resident fell and was found outside.

During an interview, a staff member #3 confirmed she conducted a well check on the resident every two hours as scheduled. She also verified the resident was alert and oriented. She mentioned she had never seen him go outside at night.

During the investigation, the investigator was unable to interview the AP despite multiple attempts.

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. The resident was deceased.
**Family/Responsible Party interviewed**: No, attempts to interview were not successful.
**Alleged Perpetrator interviewed**: No, attempt to interview were not successful.

**Action taken by facility:**
The facility initiated an internal investigation and subsequently terminated the AP. A meeting took place to re-educate all staff about the importance of well checks.

**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
Waseca County Attorney
Waseca City Attorney
Waseca Police Department
Minnesota Department of Human Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30450 | A. BUILDING: _____ B. WING _____ | C 10/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONY COURT | 200 22ND AVENUE NE WASECA, MN 56093 |

| (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<br><br>On October 23, 2023, the Minnesota Department of Health initiated an investigation of complaint HL304506625M/HL304502387C . The following correction order is issued, tag identification 2360. | 0 000 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual alleged perpetrator 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. | |