

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304558967M
Compliance #: HL304556492C

Date Concluded: February 15, 2024
Date Amended: September 19, 2024

Name, Address, and County of Licensee

Investigated:

Hawley Senior Living
923 5th Street
Hawley, MN 56549
Clay County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Amended By: Matt Heffron, JD
Operations Manager

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 facility neglected the resident when staff failed to address a change in the resident's condition after symptoms of a stroke were observed resulting in a delay in care and the resident was admitted to the hospital for a stroke.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Although a single unlicensed staff member failed to timely report an observation of slurred speech, resulting in failure to provide care according to the standard of practice, the incident was an error in therapeutic conduct. When additional symptoms were identified later in the morning, emergency medical services were contacted, and the resident was sent to the hospital for evaluation and treatment. The resident was diagnosed with a stroke, treated, and returned to her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident's medical record, hospital records, employee training records, staff schedules, and the police report.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included cognitive impairment, type two diabetes, and a history of a stroke. The resident's service plan included assistance with dressing, grooming, bathing, behavior management, medication administration, and RN supervision of monthly INR (international normalized ration, a lab value that looks to see how well your blood clots) checks. The resident's assessment did not mention the resident having difficulty talking or having slurred speech when waking in the morning.

The resident's record indicated at 12:05 p.m., staff called the on-call RN to report "resident is having left sides droop. Weakness not feeling well being sent 911 [sic]."

The police report indicated 911 was called at 12:05 p.m. Law enforcement responded to the 911 call along with emergency medical services (EMS). The police report indicated the resident had slurred speech around 7:10 a.m. but went back to bed. When the resident got up at 11:30 a.m., slurred speech and facial drooping were noted and 911 was contacted.

The resident's hospital admission documentation indicated the resident woke up at 7:30 a.m. and was noted by staff to have slurred speech. "Staff put her back to bed because they thought she was sleepy." When the resident woke up at 11:30 a.m., "she still had slurred speech, so the resident was sent to the emergency room." Another note from a hospital provider indicated the resident arrived at the emergency room with "slurred speech and a right facial droop that improved before arrival at the ED...staff noticed the change in her speech when they woke her at 7:10 but associated it with waking her from a deep sleep and her speech had not improved when they reevaluated it at 11:30." The resident had an MRI (imaging) scan completed and was diagnosed with a stroke. The resident was hospitalized for two days, returned to her baseline condition, and was readmitted to the facility.

During an interview, the clinical nurse supervisor (CNS) stated the staff member who noted the initial slurred speech was an unlicensed staff member and "she probably handled it to the best of her knowledge, I would bet she didn't think stroke."

During an interview, the unlicensed direct care staff member stated she had gone in to give the resident her medications between 7:00 a.m. and 7:30 a.m. on the morning of the incident. The resident was sleeping in the chair and the staff member woke the resident up and asked her if she would like to take her medications. The resident stated she wanted to receive her medications. The staff member stated the resident's voice was "kinda off" during this exchange, but the staff member attributed it to having just woken the resident up and "left it at that." The

staff member stated she checked back on the resident about an hour and a half later, and the resident was in bed. At that time, the staff member noticed the resident's "speech was more slurred" and there was "a little bit of droopiness." The staff member then called another employee to take a second look. The other employee described her observations of the resident as "stroke like symptoms." The staff member got the on-call phone and called 911. The staff member stated she did not recall being trained on identifying stroke symptoms. When asked further about the resident's voice being "off" around 7:00 a.m., the staff member described it as "just a little slurred."

During an interview, the on-call registered nurse (RN) stated she was first notified of the slurred speech and facial droop at 12:06 p.m. and was not aware if stroke symptoms were first observed around 7:00 a.m. The RN stated since 911 was called, she did not ask any additional questions about the onset of symptoms and did not complete any further investigation of the incident.

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; due to cognitive impairment

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

No action taken.

Action taken by the Minnesota Department of Health:

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

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

Clay County Attorney

Hawley City Attorney

Hawley Police Department

Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30455	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/08/2024
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NAME OF PROVIDER OR SUPPLIER HAWLEY SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 923 5TH STREET HAWLEY, MN 56549
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>AMENDED ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL304558967M/# HL304556492C</p> <p>On January 8, 2024, 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 34 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>A correction order was issued for #HL304558967M/# HL304556492C, tag identification 2310.</p> <p>On September 19, 2024, the correction order was amended. The content was changed, with no change to the scope and level of the violation. The finding, via the follow-up visit, that the violation was corrected as of May 21, 2024, is also unchanged.</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> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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0 000	Continued From page 1 On January 29, 2025, the correction order was rescinded. No correction orders are issued from this visit.	0 000		