

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304894823M
Compliance #: HL304898220C

Date Concluded: November 20, 2023

Name, Address, and County of Licensee

Investigated:

Potter Ridge
1791 Neal St
Red Wing MN 55066
Goodhue County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier
Special Investigator

Finding: Not Substantiated

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 the resident was found dead in his room, on the floor after an apparent fall, with blood round his head.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident was found dead in his apartment early in the morning. The resident was independent in his room and would call for help if needed. The resident was not on safety checks.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted family members and the coroner's office. The investigation included review of medical records, facility records, facility policies and trainings. Also, the investigator observed interactions between staff and facility residents, residents with residents, and staff with staff and staff with visitors.

The resident resided in an assisted living facility in his own apartment. The resident's diagnoses included high blood pressure and history of stroke with long-term anticoagulant (blood thinner) use. The resident's service plan included assistance with housekeeping, meals, and medication administration. The resident's assessment indicated the resident was independent with all mobility, including toileting, but could become unsteady and to use a wheeled walker to help stabilize him. The same document indicated he was alert and oriented but with some forgetfulness.

One day, a staff member went to give the resident his morning medications and found the resident on the floor of his apartment with blood around his head. The staff member called for help and 911 was called. EMS arrived and declared the resident deceased.

The resident's records showed the resident was on Eliquis, a blood thinner, which he took twice a day. His record also indicated the resident had fallen 3 times in the prior 2 months.

The resident's assessments indicated the resident had been given an emergency call pendent and was educated on how to use it, but the resident refused to wear it. After each fall, the RN reviewed the use of the call pendent with the resident, but he continued to refuse to wear it.

The resident records indicated it was common to give the resident his evening medications and instructed to call if he needed any assistance, but staff would not see him until the next morning. The resident's service plan did not include safety checks.

The facility documents titled "Fall" indicated the resident had multiple previous falls and an internal investigation was done. The same document indicated the resident did not use his walker consistently and did not wear his pendent.

The resident's progress notes indicate the family was called and informed of the fall and the findings from the internal investigation.

The medical examiners report indicated the cause of death was hypertensive and atherosclerotic cardiovascular disease. The same document indicated there was no injury or trauma caused the death. It was unclear whether the resident struck his head on something when he fell or if it was the impact of hitting the floor that caused him to bleed.

During an interview, a facility nurse stated she worked closely with the resident and tried to get him to wear the call pendent, but he refused, instead he would hang it on the lamp beside his chair in his room. She talked to him about wearing the pendent on multiple occasions. She stated it was normal for this resident, and many other residents living in apartments, that the staff would not see them all night based on the services provided for each individual and it would only be necessary to go into an apartment during the night if the resident called for assistance.

During an interview, a family member stated they understood the resident a heart attack was the cause of death.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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, deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility reported the falls to the family, educated the resident on fall prevention and emergency pendent use.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/05/2023
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NAME OF PROVIDER OR SUPPLIER POTTER RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1971 NEAL STREET RED WING, MN 55066
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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
0 000	<p>Initial Comments</p> <p>On October 5, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL304898220C/#HL304894823M. No correction orders are issued.</p>	0 000		

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