Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305996507M
Compliance #: HL305992306C

Date Concluded: January 30, 2024

Name, Address, and County of Licensee Investigated:
Whispering Oak Place
903 Calverly Ct
Ellendale, MN 56026
Steele County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Findings: 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):
Allegation #1: The facility abused the resident when multiple bruises were discovered on the resident's arms and legs.

Allegation #2: The facility neglected the resident when the resident was found lying in bed and soiled on several occasions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident family member and the hospice agency. The investigation included review of facility progress notes, incident reports, service plan, medications, treatments, and hospice records. During an onsite visit, the investigator made observations of staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included: dementia, anxiety, protein calorie malnutrition, and fall history. The resident's facility assessment indicated the resident required full help with bathing, dressing, transfers, and toileting needs. This same document indicated the resident required check and change every two hours related to incontinence and repositioning to prevent pressure sores.

The resident was enrolled in hospice. The resident's hospice care plan indicated services to included weekly nursing visits, hospice aide to assist with weekly shower, and massage therapy for tension and circulation. The hospice plan of care indicated hospice provided a Hoyer lift (mechanical lift with sling used to lift and transfer) for two staff to transfer the resident from bed to wheelchair and wheelchair to bed. The resident's assessment indicated the resident was at risk for abuse as she is difficult to understand, and staff members had been trained to report any suspected abuse to facility manager.

Investigative Findings and Conclusion:

Allegation #1: The Minnesota Department of Health determined abuse was not substantiated. Although the resident presented with multiple bruising, both facility staff and family member stated the resident's skin was fragile along with her long history of bruising that resident had experienced before entering the facility.

The resident's care plan indicated the facility was aware of the resident's prone to bruising on both arms and legs. At times resident displayed agitation and physical aggression towards staff members including kicking, hitting, pinching, and biting. At times, the resident would fold her arms tightly to her body to her chest to prevent cares.

The assessment indicated the resident was at high risk for falls and did not walk. The progress notes documented occurrence of falls which resulted in skin tears and bruising. The medical record indicated the resident's behaviors included striking out at staff members and kicking. The use of the Hoyer lift sling for transfers in combination with the resident's behaviors increased the risk of bruising to arms, hands, and legs. Facility progress notes indicated monitoring of skin and wounds were completed both by the facility and hospice.

Hospice services included weekly nurse visits along with a home health aide who provided one shower a week. The hospice services increased as the resident's health declined. Hospice provided medical equipment such as a knee pillow to place between resident's legs due to her history of bruising, specialty mattress, and a Broda chair (chair that provides supportive positioning) to alleviate pressure to bony areas. The same documents indicated resident had arm edema compression wraps were used to decrease the edema (swelling) along with heel protectors to prevent heel breakdown.

During an interview, an unlicensed caregiver stated the resident was on hospice cares and required a mechanical lift and two staff for transfers and bed mobility. The caregiver stated the resident had periods of resistance by striking out, biting, and hitting staff. The resident bruised easily even when just touched. The resident's refusal of care or skin concerns were documented.

Multiple hospice nurses were interviewed and concurred that the hospice admitting diagnosis was severe protein and calorie deficient malnutrition. The resident did experience frequent falls as she was not aware of her deficits. Nurse #1 stated the resident experienced bumps, bruises, and skin tears. Nurse #1 stated there was discussion of relocating the resident to another facility due to falls and bruising. Nurse #2 stated she took over the resident's hospice cares during the last six months prior to her death. She stated the resident required additional assistance due to her expected decline in health such as an increase from one person to two people for transfers and cares. Nurse #2 said the resident had extremely fragile skin and provided teaching and assistance to help elevate limbs and reduce swelling.

During an interview, a family member stated the resident has always bruised easily. The family member stated the resident would fight and strike out at staff during cares. She stated she witnessed the staff members offers cares that the resident sometimes refused.

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

Allegation #2: The Minnesota Department of Health determined neglect was not substantiated. The resident at times refused cares, which was consistent with the facility staff members documentation. The residents' refusals included times when the resident was incontinence and frequently would not allow staff members to change her.

The assessment indicated the resident preferred to sleep late in the morning and majority of the days she preferred to sleep all day. The same document indicated she was also incontinent of bowel and bladder. The care plan indicated the resident was to be checked and changed every two hours and as needed.

The progress notes indicated that at times the resident refused to get out of the bed and would be in bed the entire duration of a shift and into the next shift. When the resident refused cares the staff members would reapproach and/or have a different staff member or nurse offer cares.

Hospice records indicate the resident's health declined and would sleep for exceptionally long periods. The same notes indicated resident would have arm edema compression wraps were used to decrease the edema along with heel protectors to prevent heel breakdown. Facility staff worked closely with hospice staff to provide care.

During an interview, unlicensed caregiver stated the facility had trained staff on how to approach the resident during refusals, but also about the residents' right to refuse cares.

During an interview hospice nurse #1 stated she did at times find the resident with soiled with dried bowel movement during hospice visits. The licensed hospice staff (RN-1) stated this was from resident being in bed for extended periods of time.

During an interview hospice nurse #2 stated he worked with the facility to provide medical equipment for resident comfort. Nurse #2 stated the facility contacted her with any concerns and she increased hospice nurse visits and hospice aide visits as the resident declined.

During an interview, a family member stated the resident goes through patterns where she will sleep for days and not allow staff to perform cares. The family member stated refusing cares by holding her arms tightly over her chest and staff attempting interventions to care for the resident. The family member stated she was there almost daily and felt the resident received diligent care by the facility.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
No action required.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30599	A. BUILDING: _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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 December 7, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL305992306C/#HL305996507M. No correction orders are issued.	0 000		