Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL30803001M
Compliance #: HL30803002C

Date Concluded: October 14, 2021

Name, Address, and County of Licensee Investigated:
The Wealshire of Bloomington
10601 Lyndale Avenue South
Bloomington, MN 55420
Hennepin County

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

Evaluator's Name: Shannan Stoltz, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) neglected the resident when the AP left the resident's bed in a high position. The resident fell out of bed and sustained leg fractures.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the resident's maltreatment. The facility failed to create and implement new fall interventions after repeated falls, including a previous fall with a serious injury. The resident fell out of bed, suffered serious injury, and died.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included interviews with the resident's family members. The investigation included an onsite visit for observations, review of medical records, and review of facility policies and procedures.

The resident's medical record was reviewed. The resident's diagnoses included dementia, diabetes, and high blood pressure. The resident's signed service plan indicated she received services for medication management, nurse visits to include assessment/monitoring of changes in health status, and assistance with activities of daily living.

The resident's medical record indicated a pattern of behavior over several months of her repeatedly climbing out of bed, which then led to falls. During this timeframe, the facility did not address these safety concerns with any new interventions.

The resident's nurse notes indicated the resident suffered a non-injury fall during 2020. Notes indicated that staff found the resident on the floor, near her bed. The facility was unable to provide information on new fall interventions put in place for the resident after this fall.

Six months later, the resident fell again while trying to get out of bed. The resident suffered serious injury, which required corrective surgery and a four-day hospital stay. The facility was unable to provide specific documentation of any new fall interventions put in place for the resident after this fall. Comparison of the available documentation, including the resident's vulnerability assessment and the available care cards, appeared to show no new interventions were attempted.

Five months later, the resident fell again while trying to get out of bed. The resident suffered serious injury which required transport, then admittance to the hospital. Due to the resident's poor rehabilitation potential, surgeons were unable to perform surgery to correct the resident's injuries. The resident discharged back to the facility two days later. The resident died 11 days later. The resident's death certificate listed the immediate cause of death as complications of right tibia and right fibula fractures, and the underlying cause of death as a fall.

The resident's care card in place at the time of the last fall did not indicate the resident was a high fall risk. It did not indicate the resident's known and documented repeated attempts to climb out of bed, nor did it list interventions to address the repeated falls. The only intervention listed was for the resident to have a pull-tab alarm (type of audio alarm), on at all times. The facility had implemented this intervention, 2 ½ years prior to the last fall, when the resident moved into the facility.

During an interview with a direct care staff member, she stated that the facility did not update interventions for any of their residents. The staff member stated that this resident had a pull-tab alarm, but no other fall risk interventions in place, and the resident was always climbing out of bed, or always trying to. She stated that whenever she found the resident doing this, she advised the floor nurse.

During an interview with the alleged perpetrator (AP), she stated she performed care on the resident the morning of the resident's last fall. The AP stated when she left the resident's room, she forgot to put the resident's bed all the way down, and the resident fell out of bed approximately 20 minutes later. The AP stated that the resident would always climb out of bed, and that she passed this information on to the floor nurse. The AP stated the facility did not implement any new fall interventions for the resident, nor provide any fall-prevention training specifically related to the resident, after any of the resident's falls.

During an interview with the unlicensed personnel (ULP) staff member who found the resident, she stated she heard the resident screaming for help, and went to her room. This ULP stated the resident was lying on her back, with the lower half of her body under her bed, and her right leg appeared to be stuck between the floor and the bed frame. This ULP stated she called the licensed practical nurse (LPN) on the radio, then raised the resident's bed approximately five inches with the remote control, to free the resident's leg. This ULP stated the LPN entered the room approximately 30 seconds later and took over the fall scene. This ULP stated the resident was a high fall-risk and continually climbed out of bed, and every time this ULP discovered this, she would pass the information on to the floor nurse. This ULP stated other high fall-risk residents had motion-sensors in their rooms (that would send an alert of movement to the nurse's station), or thick pads near their beds, but this resident did not have those. This ULP stated she did not know why these fall interventions were not in place for this resident.

During an interview with the RN, she stated that when the resident moved into the facility approximately 2 ½ years prior, the RN deemed the resident a fall risk, and implemented a tab-alarm as an intervention. The RN stated this was the only intervention listed on the resident's care card. The RN stated other available interventions at the facility were a motion-sensor placed in a resident's room and a thick mat placed near a resident's bed, and there was "no real rationale" as to why those interventions were not offered to this resident. The RN stated the process for ULPs was to report concerns to an LPN, and the LPN would pass them to her (the RN). The RN stated no staff ever advised her the resident was frequently found sitting on the edge of her bed or had repeatedly climbed out of bed. The RN stated that she did not create additional interventions for the resident after the falls and was unable to say why.

During an interview with the LPN, she stated she worked the morning of the resident's fall. The LPN stated that when she responded to the resident's room, the resident was on the floor and the bed was in a high position. The LPN stated she rendered aid, called 911, hospice, and family, and then administered a controlled substance medication for pain as the resident was "in excruciating pain." The LPN stated there were no new interventions created and implemented after the resident's prior falls, and she did not know why. The LPN stated that ULPs had advised her different times that they had found the resident sitting on the edge of her bed or having climbed out of bed. The LPN stated she passed this information onto the next shift (nurse) during verbal nurse-to-nurse report and via the 24-hour written report. The LPN stated the RN was present during report, so she would have heard that the resident kept climbing out of bed. The LPN stated the RN was the supervisor who signed the 24-hour written reports, so she would have read that the resident kept climbing out of bed. The LPN confirmed that some facility interventions used to prevent falls were a motion-sensor audio alarm and floor mats, but that this resident did not have these interventions. The LPN stated that the resident should have had the interventions as the resident was a fall risk who always tried to get out of bed.

During an interview with a family member, he stated the facility never had any discussions with the family about fall interventions for the resident. The family member stated the resident moved into the facility approximately 2 ½ years prior to her last fall, but that he had never met the RN, or spoken with her on the phone, in reference to the resident's care, falls, or interventions. The family member stated he had received emails from the RN, but the emails were requests to sign documentation/service plans, etc.

In conclusion, neglect was substantiated. The facility failed to attempt new fall interventions after the resident experienced previous falls with serious injury. This contributed to the fall which caused the

resident's death.

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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No; deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Alleged perpetrator is no longer employed by 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
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.
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
Hennepin County Attorney
Bloomington City Attorney
Bloomington Police Department
Hennepin County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30803	A. BUILDING: _____ B. WING _____	C 09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WEALSHIRE OF BLOOMINGTON	10601 LYNDALE AVENUE SOUTH BLOOMINGTON, MN 55420

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G., the Minnesota Department of Health issued correction orders pursuant to a survey. 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. INITIAL COMMENTS: On September 21, 2021, the Minnesota Department of Health initiated an investigation of complaint HL30803001M, HL30803002C. At the time of the survey, there were 103 residents receiving services under the assisted living license. The following correction orders are issued for HL30803001M and HL30803002C, tag identification 2310, 2360.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.	
02310 SS=J	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 1 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide care in accordance with accepted healthcare standards for one of one residents (R1) reviewed when the resident suffered repeated falls, and the facility failed to create and implement new interventions to address the falls. The facility did not discuss appropriate resident care/interventions with the resident's representative and did not attempt new fall precautions. As a result, the resident experienced continued falls, including one which resulted in serious injury. The resident's death certificate listed injuries sustained in that last fall as the cause of her death. This practice resulted in a level four violation (a violation that results in 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). Findings Include: R1's medical record was reviewed. The resident's medical diagnoses included dementia, diabetes, and high blood pressure. R1's signed service plan, dated October 1, 2020, indicated she received services for medication management, nurse visits to include assessment/monitoring of changes in health	02310		

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02310	Continued From page 2 status, and max-to-total assistance with activities of daily living. Records indicated the resident moved into the facility in May 2019. R1's Nurse's Notes dated September 20, 2020, at 3:45 pm, indicated the resident suffered a non-injury fall in her room. Notes indicated, "Resident observed on floor by staff laying on her back parallel to her bed." The Resident Incident Report and Resident Care Card dated September 20, 2020, were requested, but not received. In an email from the facility's registered nurse (RN)-A dated October 7, 2021, RN-A indicated, "Do not have incident report from 9-20-20 as incident reports are destroyed after 60 days and old care cards...". The facility could not provide any documentation for fall interventions put into place after the resident's September 2020 fall. In an email from RN-A dated September 23, 2021, at 12:23 pm, she indicated, "Interventions for care needs are listed on the care card ..." The Resident Incident Report dated March 18, 2021, at 2:35 am, indicated the resident fell while trying to get out of bed, and suffered serious injury. Emergency medical services transported the resident to the emergency room, and the resident was subsequently admitted to the hospital. The resident's hospital notes dated March 19, 2021, at 10:54 am, indicated the resident suffered a left femur fracture that required corrective surgery, which surgeons performed during resident's four-day stay in the hospital. The resident's facility Nurse's Notes dated March	02310		

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02310	Continued From page 3 22, 2021, at 1:00 pm, indicated the resident returned to the facility at 11:45 am. The Resident's Care Card for the March 2021 fall was requested, but not received. The facility could not provide any documentation for fall interventions put into place after the resident's March 2021 fall. The Resident's Care Card dated July 16, 2021, was the card in place when the resident fell again on August 1, 2021. The card did not indicate the resident was a high fall-risk, the resident's repeated attempts to climb out of bed or any interventions to address this. The only intervention listed, implemented in May 2019, was for the resident to always have a tab alarm (type of audio alarm) on. The resident's Nurse's Notes, dated August 1, 2021, at 10:00 am, indicated the resident suffered a fall (in an attempt to get out of bed) at approximately 7:00 am that morning. Notes indicated staff found the resident half-way under her bed with her right leg twisted up behind her buttocks and "screaming in severe pain." Notes further indicated staff called emergency medical services, who transported resident to the emergency room, where the resident later was admitted to the hospital. Family-provided photographs of the scene of resident's August 1, 2021, fall showed the resident lying on her back on her bedroom floor. The resident's head was next to the foot-end of her bed with her left leg pointed towards the head of her bed. The resident's body, from the waist down, was underneath her bed, and her right leg was bent up towards her buttocks at an approximate 45-degree angle.	02310		

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02310	Continued From page 4 The resident's hospital notes dated August 1, 2021, at 11:29 am, indicated the resident suffered a fractured right leg tibia and fibula (long bones in the lower leg), but hospital surgeons could not perform corrective surgery due to the resident's poor rehabilitation potential and non-operative management. Notes indicated that the resident discharged back to the facility on August 3, 2021, in the evening hours. Facility provided document Resident Monitoring Visit Notes signed and dated by RN-A on August 2, 2021, indicated RN-A performed a monitoring visit. The document does not address specific fall risk/potential contributing factors/evaluate potential interventions to reduce or eliminate risk issues specifically related to falls. The resident's facility Nurse Notes showed no nurse documentation on the resident from the time she returned from the hospital (August 3, 2021) until August 4, 2021, at 3:00 a.m. At the 3:00 a.m. hour, the first note in the residents' records written by unlicensed personnel noted the resident was restless with pain. In an email chain dated September 23, 2021, between this investigator and RN-A, this investigator requested the resident's facility Nurse's Notes for the dates of August 1, 2021, through August 4, 2021, at 2:59 am. RN-A indicated there was no nurse documentation for that timeframe. The resident's 24-hour Reports were requested from the facility, but not received. The resident's Nurse Notes dated August 11, 2021, at 2:07 am, indicated that resident had no	02310		

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02310	Continued From page 5 signs of life and had died. Notes indicated family was present. The resident's Death Certificate dated August 11, 2021, listed the resident's immediate cause of death as, "Complications of right tibia and right fibula fractures (not operated)," and the underlying cause of death as "fall." During an interview on September 22, 2021, at 3:00 pm, unlicensed personnel (ULP)-B stated the facility did not update interventions for any residents. ULP-B stated the resident had a pull-tab alarm, but no other fall risk interventions were in place. ULP-B stated the resident was "always climbing out of bed, or always trying to" and that when ULP-B found the resident doing this, she advised the floor nurse. During an interview on October 1, 2021, at 2:00 pm, ULP-J stated she was the aide who performed care for the resident on the morning of the August 2021 fall. ULP-J stated she was in the resident's room for approximately 20 minutes, then left to go assist other residents with morning cares. ULP-J stated that when she left the resident's room, she forgot to put the resident's bed all the way down. ULP-J stated that after the resident's serious fall in March 2021, the facility did not implement any new fall interventions for the resident nor provide any fall-prevention training related to the resident. ULP-J stated that the resident would always climb out of bed, and she passed this information on to the floor nurse. During an interview on October 4, 2021, at 9:00 am, RN-A stated she received a call from LPN-H mid-morning on August 1, 2021. RN-A stated that licensed practical nurse (LPN)-H advised her that the resident had suffered a serious fall from her	02310		

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02310	Continued From page 6 bed, and that the bed had appeared to be in the highest position. RN-A stated she instructed LPN-H to have both ULP-J and ULP-K complete written statements on the occurrence. RN-A stated she called ULP-J on August 2, 2021, during which ULP-J admitted she had left the residents bed in the highest position. RN-A stated she terminated ULP-J based on policy violations. During an interview on October 4, 2021, at 11:00 am, ULP-K stated on the morning of the resident's August 2021 fall, she heard the resident screaming for help and went to her room. ULP-K stated the resident was lying on her back with the lower half of her body under her bed and her right leg appeared to be stuck between the floor and the bed frame. ULP-K stated she called the nurse on the radio, then raised the resident's bed approximately five inches with the remote control in an attempt to free the resident's leg. ULP-K stated LPN-H entered the room approximately 30 seconds later and took over the fall scene. ULP-K stated that when she entered the room, the bed was not in the lowest position, but was at "waist level." ULP-K stated the resident was a high fall-risk and continually climbed out of bed. ULP-K stated when she discovered this, she would pass the information on to the floor nurse. ULP-K stated other high fall-risk residents had motion-sensors in their rooms (that would send an alert of movement to the nurse's station), but this resident did not have one. ULP-K stated other high fall-risk residents had thick floor mats near their beds, but this resident did not have one. ULP-K stated she did not know why these fall interventions were not in place for this resident. During an interview on October 5, 2021, at 9:30 am, RN-A stated the resident moved into the	02310		

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02310	Continued From page 7 facility in May 2019 was deemed a fall risk and implemented the intervention that the resident wear a tab-alarm at all times. RN-A stated resident interventions were listed on their Care Cards, which are mounted on the resident's closet doors. RN-A stated another intervention available at the facility was for a resident to have a motion-sensor in their room (movement in the room would trigger a loud audible alarm at the nurse's station). RN-A stated the facility did not provide the resident a motion-sensor alarm due to the distance of the resident's room from the nurse's station (the distance would cause interference with other alarms). RN-A stated that the motion-sensor alarms do not always work, and that staff do not always know whose motion-sensor alarm is alerting. RN-A stated the facility did not move the resident's room closer to the nurse's station because there were no rooms available and because of COVID-19 restrictions. RN-A stated another fall intervention was to place a thick mat near a resident's bed so there would be cushion if a resident were to fall out of bed. RN-A stated they did not provide this intervention for the resident, and she had "no real rationale" except that staff would run over the mat with the resident's Hoyer lift (instead of moving the mat out of the way). RN-A stated that the facility process for unlicensed personnel to report concerns was to pass those concerns on to an LPN, and the LPN would pass the concerns on to her (the RN), so she could do an assessment. RN-A stated no staff ever told her they found the resident sitting on the edge of her bed, or that the resident repeatedly climbed out of her bed. RN-A stated if staff had advised her of this, she would have completed a safety assessment. RN-A stated the facility does not have a specific fall risk document but they train staff that all residents are a fall risk. RN-A stated that she did not create	02310		

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02310	Continued From page 8 additional interventions for the resident after the resident's falls in September 2020 or March 2021 and was unable to explain why. RN-A agreed that a resident who frequently climbed out of bed would present a greater fall risk, but again stated that no staff had advised her that the resident was doing so. During an interview on September 21, 2021, at 10:55 am, LPN-H stated she worked the morning of the August 1, 2021, fall. LPN-H stated ULP-K alerted her via the radio that the resident had fallen so she responded to the room. LPN-H stated she found the resident "all twisted up on the floor" and that the "bed was in way-high position." LPN-H stated she rendered aid and called 911, hospice, and family. She stated she then administered a controlled substance medication for pain as the resident was "in excruciating pain." LPN-H stated after the incident, she called RN-A to advise her of the situation. RN-A directed her to have ULP-J and ULP-K write statements about the fall. LPN-H stated they wrote the statements, and she placed them in a sealed envelope and put the envelope in RN-A's mailbox. LPN-H stated she did not read the statements, nor did she talk to ULP-J or ULP-K about the incident. During an interview on October 7, 2021, at 10:00 am, LPN-H stated there were no new interventions created and implemented after the resident's March 2021 fall, and she did not know why. LPN-H stated ULPs advised her several times that the resident climbed out of bed, and LPN-H passed this information onto the next shift (nurse) during verbal nurse-to-nurse report and via the hand-written 24-hour report. LPN-H stated that RN-A was present during report so she would have heard the information, and RN-A was the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30803	A. BUILDING: _____ B. WING _____	C 09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 9 supervisor who signed the 24-hour written reports. LPN-H confirmed that some facility interventions used to prevent falls were a motion-sensor audio alarm and a floor mat, but that the resident did not have these interventions implemented or listed. LPN-H stated the resident should have had them, and the resident was "an important fall risk [who] always tried to get out of bed." During an interview on September 27, 2021, at 1:00 pm, family member (FM)-I stated that the facility never had any discussions with family about fall interventions for the resident. FM-I stated the resident moved into the facility in May 2019, but that he had never met RN-A or spoke with her on the phone in reference to the resident's care. FM-I stated that he instead received emails from RN-A, but the emails were requests to sign documentation/service plans, etc. Facility provided document for Fall Prevention & Reduction dated January 1, 2018, indicated, "Based on the RN's initial assessment of the resident, and any re-assessments, if the RN believes the resident is at risk for falls, the RN will conduct a monitoring visit to assess potential contributing factors for falls, evaluate potential interventions to reduce or eliminate the risk, update the resident's representative and make recommendations for preventative actions, such as physical therapy, exercise, etc." TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02360	Continued From page 10	02360		
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: Based on interviews and document review, the facility failed to ensure 1 of 103 residents reviewed was free from maltreatment. The resident was neglected. Findings include: On October 14, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents, which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	