Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30815001M
Compliance #: HL30815002C

Date Concluded: March 22, 2022

Name, Address, and County of Licensee Investigated:
West View Assisted Living Apt.
240 6th Avenue North
Osakis, MN 56360
Douglas County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jill Hagen, 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 facility staff neglected the resident when the resident fell and was unable to call for staff assistance. As a result, the resident laid on the bathroom floor for approximately 14 hours.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The wall mounted call system in the resident's bathroom failed to activate following the resident's fall. The resident laid on the bathroom floor for approximately 14 hours after falling. The resident was hospitalized and fractured five ribs.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigation included a review of the resident's medical and hospital records, review of staff schedules, audits of call pendant

functioning, a tour of the facility and the resident's apartment, and facility policies and procedures.

The resident had diagnoses including chronic obstructive pulmonary disease and osteoporosis (brittle and fragile bones). The resident made his needs known and required staff assistance for bathing, laundry, housekeeping, meals preparation, and weekly medication management. Staff provided meal tray service to the resident for breakfast, otherwise the resident had his meals in the facility dining room. The resident used a walker when ambulating and an electric scooter for distances.

The facility call system to request staff assistance included a call pendant which the resident could wear either on a necklace or on his wrist, and the resident also had a wall mounted call pendant next to the toilet in the bathroom.

A facility incident report indicated one morning when unlicensed staff brought the resident's breakfast tray to his apartment, the resident was found on the bathroom floor laying on his back in urine. The resident said he fell the evening prior around 5:00 p.m. when attempting to put on his incontinent product. The resident left his necklace call pendant next to his recliner in the living room area, so he pulled the cord on the wall mounted call light in the bathroom which failed to activate. The incident report indicated when the resident was found he had bruising on the right side of his face and complained of extreme pain with movement in his lower back and right lower rib cage. Facility staff arranged for the resident's to be evaluated at the hospital.

The hospital record indicated the resident fractured five ribs on the right side after the fall. The resident was admitted to the hospital for three days and transferred to a long-term care facility for therapy after hospital discharge.

During an interview, management stated prior to the resident's fall, unlicensed staff checked on the resident before the evening meal. The next contact staff had with the resident occurred the next morning (approximately 14 hours later) when staff delivered the resident's breakfast tray. Management stated despite the failure of the resident's call light malfunctioning, when the resident failed to show up for the evening meal in the dining room, staff should have checked on him. Prior to the incident of the resident's wall mounted call light not functioning, the facility did not have a system to check the functioning of each wall mounted call unit. Since the incident, maintenance staff check the functioning and battery of all wall mounted call lights in the facility on a scheduled basis. In addition, each resident had an evening safety check by staff added to their service agreement.

In conclusion, neglect occurred. The facility was responsible for the maltreatment. The resident fell and attempted to call for staff assistance. The staff found the resident approximately 14 hours later laying on the bathroom floor in pain with fractured ribs.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented a system to test the functioning of the call pendant unit and battery.
The facility implemented an evening safety check for all residents and educated staff to check for resident safety if they miss a meal.

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/facilites/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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Douglas County Attorney

Osakis City Attorney
Osakis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30815	A. BUILDING: _____ B. WING _____	C 03/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST VIEW ASSISTED LIVING APT	240 6TH AVENUE NORTH OSAKIS, MN 56360

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 482/144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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: #HL30815002C/#HL30815001M On March 15, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 21 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL30815002C/#HL30815001M, tag identification 2360.	0 000	Minnesota Department of Health is documenting 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 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 evaluators ' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On March 15, 2022, 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.	