Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL31337004M
Compliance #: HL31337005C

Date Concluded: June 22, 2022

Name, Address, and County of Licensee Investigated:
Highland Gracewood
1925 Graham Avenue
St. Paul, MN 55116
Ramsey County

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

Evaluator's Name: Stacia Hansen, RN
Special Investigator

Finding: Substantiated, individual 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) 2 left the resident on the floor after she was found then AP 1 picked the resident up and left her sitting alone in a chair.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrators were responsible for the maltreatment. AP1 and AP2 did not follow facility policy and contact a nurse after the resident was found on the floor. Also, the resident sustained a hip fracture and was not provided medical attention immediately due to the AP's actions.

The investigation included interviews with facility staff members, including a registered nurse (RN), licensed practical nurse (LPN) and unlicensed personnel (ULP). The investigation included a tour of the facility, review of the resident's medical records, incident reports, employee training records and facility policies and procedures.

The resident resided in a memory care unit in an assisted living facility. The resident's diagnoses included anxiety and Alzheimer's disease. The resident's service plan included services such as bathing assistance, medication administration and reassurance checks.

The resident's progress notes indicated one morning the resident was found on the floor at approximately 9:00 a.m. but nursing staff was not informed of the incident. Two and half hours later that morning the resident was found sitting in a chair in her room and she complained of right hip/leg pain. The nurse called 911; the resident was transported to the hospital and admitted for surgery to repair a hip fracture per the progress note.

The facility's internal investigation report indicated AP1 said AP2 found her in the hallway and reported to her the resident was on the floor in her room and he could not help because he had to pass medications. AP2 reported he found the resident on the floor in her room when he went to give her morning medications and he called on the walkie for AP1 to assist since the resident does not like male caregivers.

During an interview, the RN stated she arrived at the facility around 8:20 a.m. on the day of the incident and did not hear any conversations over the radio (or "walkie") during the morning. The RN stated the LPN called her at 11:30 a.m. to come to room 33 immediately. The RN stated the resident was sitting in a chair in her room holding her leg and wincing in pain. The RN said she interviewed facility staff members after the incident.

During an interview, the LPN stated she went to check on another resident when AP1 notified her the resident was sitting on a chair in her room and crying. The LPN stated AP1 told her AP2 did not use the walkie to call her and just left the resident crying on the floor. The LPN stated the facility staff receive training on how to handle resident falls and it consists of not moving a resident without a nurses' permission to do so.

During an interview, the family member stated she received a phone call from the facility around 1:00 p.m. on the day of the incident and she was informed her mother was being taken by ambulance to the hospital after she had fallen. The family member said she did not think to ask what time or where the fall occurred. The family member was not aware of the resident being moved to a chair and sitting for a couple hours before receiving medical attention.

During an interview, the AP2 stated he was assigned to pass medications to residents in the assisted living and memory care units. AP2 stated he radioed the caregiver (AP1) for assistance and he would have notified the nurse if she had been there. AP2 stated his orientation and training he received if a resident fell was to notify the nurse, take vitals and write an incident report. AP2 stated AP1 was with resident 1 when he left to finish passing morning medications to the other residents in the facility.

In addition, the facility's internal investigation indicated during a second interview with AP1 she recanted her first statement and said she and AP2 assisted the resident with a gait belt. Also,

AP1 stated the resident was not crying and did not report any pain when they assisted her up to the chair.

AP1 and AP2 did not follow the facility's fall policy. The fall policy indicated in the event of a fall, the facility staff member will notify the nurse, check the resident's vital signs, check the resident's cognitive status, perform range of motion with resident, call 911 if indicated and complete an incident report.

In conclusion, neglect was substantiated.

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, due to dementia diagnosis.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: AP1 declined an interview, AP2 interviewed.

Action taken by facility:
The facility conducted an internal investigation. AP1 and AP2 were terminated after the incident. The RN filed a MAARC report. Re-education was done with facility staff members during stand up (shift change) on importance of following policy and procedure after resident falls.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.
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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31337	A. BUILDING: _____ B. WING _____	C 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND GW LLC	1925 GRAHAM AVENUE SAINT PAUL, MN 55116

(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 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: HL31337005C/HL31337004M On May 17, 2022, 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 29 clients receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL31337005C/HL31337004M, tag identification 0510 and 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 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. 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 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice has the potential to affect all 29 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents and visitors.) Findings include: The licensee failed to ensure staff wore personal protective equipment (PPE) eye protection while performing daily cares with residents. An MDH document dated February 24, 2022, titled Implementing Universal Use of Eye Protection When Community Transmission of	0 510		

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0 510	Continued From page 2 COVID-19 is High or Substantial reads: health care workers working in facilities located in counties with substantial to high community transmission are more likely to encounter asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection. HCWs working in counties with substantial or high transmission should wear eye protection (i.e., goggles or a face shield that covers the front and sides of the face) during all resident encounters. The Centers for Disease Control (CDC) COVID Data Tracker listed community transmission rate as "high" for Ramsey County at the time of the MDH on-site visit. On May 17, 2022, at 8:30 a.m., house manager (HM)-F met MDH surveyors at the front entrance wearing a face mask but no eye PPE. During an observation on May 17, 2022, at 9:50 a.m., unlicensed personnels (ULP) were wearing surgical face masks but no eye PPE while interacting with residents when a MDH surveyor toured the facility with the HM. During an interview on May 17, 2022, at 11:20 a.m., unlicensed personnel (ULP)-A wore a surgical face mask but no eye PPE. During an interview on May 17, 2022, at 1:15 p.m., registered nurse (RN)-B wore a surgical face mask but no eye PPE. During an exit interview on May 17, 2022, at 2:30 p.m., RN-B stated she thought wearing eye PPE was not needed. The HM-F stated they receive an email from corporate office with a weekly update and they were told this week's level was medium so eye PPE was not required.	0 510		

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0 510	Continued From page 3 During an email correspondence on May 17, 2022, at 4:30 p.m., RN-B stated they were looking at "Covid 19 community levels" under the "Data Type" instead of "Community Transmission" levels and she would notify her director of nursing (DON). A policy titled 8.18 Eye Protection and Face Shields, dated April 21, 2022, indicated for substantial/high county community transmission level eye protection is required in the facility when within 6 feet of a resident or another staff member or visitor. TIME PERIOD TO CORRECT: Two (2) Days	0 510		
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 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 June 22, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that two individual staff person were responsible for the maltreatment, in connection with incidents which occurred at the facility. 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.	

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