Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333112664M
Compliance #: HL333114488C

Date Concluded: June 21, 2023

Name, Address, and County of Licensee Investigated:

Lewiston Senior Living
505 East Main Street
Lewiston, MN 55952
Winona County

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

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Not Substantiated

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.

Initial Investigation Allegation(s):
Facility staff neglected the resident when they failed to provide the resident with fall interventions following each fall and as a result the resident had recurring falls and sustained injuries and multiple fractures. In addition, the resident did not receive timely assistance from staff when following a fall, the resident's call light pendant failed to work properly.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff assessed and provided care planned interventions following the resident's fall. Following a fall and despite the resident indicating she activated the call light pendant for staff assistance, the call light log (used to track call light use) did not indicate the resident activated the pendant.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the resident's family member. The investigation included review of fall incident reports, fall interventions, facility investigation findings, maintenance logs, call light logs, assessments, care plans, service agreements, physical therapy notes, and assessments. Also, the investigator observed residents and staff in the facility.

The resident resided in an assisted living facility with diagnoses including age related osteoporosis (brittle bones) with history of a pathological (spontaneous) fractures and spinal stenosis (narrowing). The resident transferred and walked independently with the use of a four wheeled walker. The resident was at risk for falls due to history of falling, with multiple interventions in place to prevent re-curing falls.

A facility incident report indicated one day the resident fell while walking independently, as care planned, with her walker outside on the facility grounds/parking lot and sustained a scrape to her knee and cheek. The incident report indicated the resident was assessed for injuries, and staff contacted emergency services for lift assistance.

Approximately seven months later, an incident report indicated when the resident failed to come to breakfast, staff checked on the resident and found her on the floor. The resident stated she felt dizzy and lost her balance when transferring from her couch to wheelchair. When staff assessed the resident for injuries, the resident complained of right shoulder pain and an inability to bear weight. Staff arranged for the resident to be evaluated at a hospital. The report indicated the resident fractured her right clavicle (shoulder bone), sternum (chest bone), and pelvis. Following hospitalization and rehabilitation, the resident returned to the facility.

The facility investigation indicated the resident reported to staff she pressed her call light pendant for help after the last fall and waited for about 10 minutes for staff assistance.

A review of the facility's call light log report indicated no call was made from the resident's call light pendant at the time of the fall.

During an interview, management stated despite the resident stating she used the call light pendant following the fall, the call light pendant had not been activated. Management stated the call light pendant system was checked and functioned properly at the time of the resident's fall.

A few days following the resident's fall, a facility maintenance record indicated the call light system failed to consistently function in certain areas of the facility. It could not be determined whether the system failure caused the resident's call light pendant to malfunction. The maintenance record indicated facility equipment and internet systems were upgraded to ensure reliable connectivity of the call light system throughout the facility.

During an interview, the resident stated she was independent with walking when she fell in the parking lot while walking outside. The resident stated staff called for an ambulance who checked her for injuries, and she declined a need for transport. The resident stated she was independent with transfers and using a walker to ambulate when she fell sustaining multiple fractures. The resident stated following the fall, she pressed her call light pendant, but it did not alert staff. The resident indicated she had no concerns about staff responding to her call light timely or the call light system working properly. The resident stated she felt safe and expressed no concerns with her care.

In conclusion, 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:
(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: N/A

Action taken by facility:
Facility staff checked on the resident timely when she did not arrive to breakfast as expected, assessed the resident for injuries, and investigated the incident. The call light system was tested and found to not work consistently in some locations. The facility upgraded the Wi-Fi system to ensure connectivity.

Action taken by the Minnesota Department of Health:
No action required.

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
	33311	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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 May 16, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL333112664M/#HL333114488C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State 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.	