Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333115803M
Compliance #: HL333119996C

Date Concluded: February 6, 2024

Name, Address, and County of Licensee Investigated:

Lewiston Senior Living
505 East Main St.
Lewiston, MN 55952
Winona County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Investigation #1 Finding: Not Substantiated
Investigation #2 Finding: Inconclusive

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 alleged perpetrator (AP), a culinary staff member, neglected the resident when the AP did not follow the resident's therapeutic diet causing the resident to choke, aspirate (inhale into the airway or lungs), and required medical attention.

Allegation #2: The facility neglected the resident when the resident took an orange from the facility fruit bowl, choked on the fruit, and passed away.

Investigative Findings and Conclusion:
Allegation #1: The Minnesota Department of Health determined neglect was not substantiated. While an error in therapeutic conduct did occur in that the resident may have been served food without direct supervision, the AP identified the resident's condition promptly, sought appropriate help, and the resident recovered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident's facility care plan, progress notes, incident reports, and behaviors. Also, the investigator toured the facility and observed the dining area and location of resident's room.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, cognitive impairment, insomnia, and anxiety. The resident's plan of care indicated the resident required assistance with meal set up, a mechanically soft food diet, and supervision when eating encouraging resident to eat slowly and take drinks of fluids between bites. This same document indicated the resident was at risk of choking related to behaviors of eating too fast and not chewing his food.

An incident report indicated that one morning the resident entered the dining room, and the AP placed a small bowl of fresh fruit in front of the resident. While the AP remained in the dining room, she did not provide direct supervision. The resident began to vomit, and the AP immediately notified the nurse. The facility transferred the resident to the emergency room.

The hospital records indicated antibiotic treatment was considered for possible pneumonia due to lung aspiration, but this was not pursued as the risk was considered low. The resident returned to the facility the same day.

The medical records indicated the resident returned to his baseline.

The AP's employee file indicated the AP was trained in the altered diet, resident's choking potential and need for supervision. A review of these documents did not identify a pattern of errors such as giving residents food inconsistent with their diet.

Facility documents included instructions to culinary staff members to assist with supervision of the resident during meals. The same instructions did not specify if caregivers were required to be present in the dining room while serving the meals.

During an interview, a nurse stated the resident was served fruit prior to unlicensed caregivers being present in the dining room. The nurse stated the culinary staff should have waited for the unlicensed staff to arrive in dining room before giving the resident fruit. Nursing staff stated the culinary staff received the same Educare (computer based) training for supervising and feeding the residents as the unlicensed caregivers. Unlicensed staff members are not trained or required have been trained in the Heimlich maneuver but are trained to notify the nurse immediately if present or call 911.

During an interview, the AP stated the resident was on a mechanical soft diet with cut fruit. The AP stated she was aware of the resident's behaviors of consuming his food to fast causing him

to choke. The AP stated she was trained in what measures to take if a resident was choking in the dining room.

During an interview, a family member stated they were happy with the cares the resident received. The family member stated during visits with the resident they observed the resident receiving good supervision from facility staff.

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

Allegation #2: The Minnesota Department of Health determined neglect was inconclusive. The facility was aware the resident required a mechanical soft diet, choking risk, and independent with ambulation. The facility continued to have fruit available to residents at all times located in the entrance of the dining room, however the resident did not have a history of taking food to his room to eat without supervision.

In addition to the description in allegation #1, the resident's care plan was updated after the incident in the dining indicating the resident had a history of lung aspirations with one within the past week. The resident walked independently throughout the facility. The resident's routine included waking up between two and four o'clock in the morning to get ready for the day. The facility provided every two-hour safety checks.

About four days after the resident's episode in the dining room staff performed a safety check in the morning. At about 5:00 a.m. the resident appeared to be sleeping in his chair, but upon closer inspection he was found unresponsive with a piece of orange in his mouth. The facility called 911 and cardiopulmonary resuscitation (CPR) was attempted, however the resident passed away.

The facility incident report indicated the resident had gone to the dining room where a fruit basket was kept and retrieved an orange and returned to his room with it.

During an interview, a nurse stated a basket of fruit was available for the residents all the time. The basket of fruit was located at the entrance of the dining room and contained oranges, bananas, and apples. The nurse stated the resident had not taken took fruit out of the basket as he waited for food to be served to him prior to this occasion. She said the overnight shift has one staff member scheduled on the assisted living side and one staff member is scheduled in the memory care unit and, at times, the staff member on the assisted living side went to memory care to assist which left the assisted living unit unattended.

During an interview, multiple unlicensed caregivers stated the resident walked outside his room independently and staff members were not always in the hallways due to providing cares. Overnight caregivers stated they performed checks on the resident every hour once awake. The same staff stated the resident at times would go down to the fruit basket and staff would

supervise him eating the fruit. Normally the resident would eat a banana but preferred oranges.

During an interview, the unlicensed caregiver who found the resident unresponsive stated he checked on resident and then returned an hour later and found him unconscious, with a visible piece of orange in the resident's mouth which the caregiver removed. The Heimlich was attempted, 911 called, and chest compressions started until emergency medical staff arrived.

During an interview, family member stated they were aware of the resident's behavioral eating habits and requiring supervision when eating. Family member stated the facility cut up his food which did not slow down the resident from consuming food rapidly. Family member stated he was aware of the sleep patterns of the resident getting up for the day early in the morning. Family member stated they were happy with the care the resident received and had no concerns.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Therapeutic conduct Statutes, section 626.5572, subdivision 20.
"Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, the resident was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided re-education to staff regarding diets and supervision in the dining room.

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
	33311	A. BUILDING: _____ B. WING _____	C 12/21/2023

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 December 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL333119996C/HL333115803M. No correction orders were issued.	0 000		