

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338813281M
Compliance #: HL338813386C

Date Concluded: May 16, 2024

Name, Address, and County of Licensee

Investigated:

Good Life Assisted Living
5260 127th Street North
Hugo, MN 55038
Washington County

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

Evaluator's Name: Peggy Boeck, RN,
Special Investigator

Finding: Not Substantiated

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):

The facility neglected to supervise residents when resident #2 pushed down resident #1, who fractured her hip and later died. The medical examiner determined the manner of resident #1's death was homicide.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Resident #2 had a history of aggressive response to uninvited touch from others and a startle response to approaches from behind. Resident #2 had no history of going out of her way to push a peer or initiate an aggressive interaction with other residents. Staff observed both residents one minute before the incident and responded immediately after the incident. The facility provided supervision and cares for residents 1 and 2 according to their individual service plans. The incident could not have been anticipated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and law enforcement. The investigation included review of the resident records, death record, facility internal investigation, facility surveillance video, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff/resident interactions.

Resident 1 lived in the locked memory care unit. Resident 1's diagnoses included Alzheimer's dementia. Resident 1's service plan included assistance with bathing, toileting, dressing, grooming, meals, medication management, housekeeping, laundry, and every two-hour safety checks. Resident 1 also received hospice services from an outside agency for several months prior to the incident. Resident 1's assessment indicated resident 1 enjoyed independent walks around the unit.

Resident 2 lived in the locked memory care unit. Resident 2's diagnoses included dementia with agitation. Resident 2's service plan included assistance with bathing, toileting, dressing, grooming, meals, medication management, housekeeping, laundry, and two-hour safety checks. Resident 2's assessment indicated resident 2 independently walked around the unit. Resident 2's assessment indicated resident 2 became agitated/aggressive when touched, experienced rapid mood shifts, with episodes of laughing/crying, and verbal outbursts. Resident 2's service plan directed staff to take a slow approach with resident 2, redirect, and reapproach when aggressive. Resident 2's progress notes indicated she had one incident of pushing a peer who was too close to her but took out most aggressions on inanimate objects (doors, walls, tables) and staff. Resident 2's record indicated her doctor made multiple medication changes before and after the incident.

An incident report indicated a staff member observed resident 1 laying on the floor in front of the sunroom, crying. The report indicated the staff notified the nurse and stayed with resident 1. The report indicated resident 2 pushed resident 1.

During an interview, the staff member who found resident 1 on floor stated that she and the other staff were in a resident room when they heard a scream. The staff member stated she went out into the hall and saw resident 1 on the floor outside the sunroom, which was two doors away. The staff member stated resident 1 pointed to resident 2, who walked out of the sunroom, when the staff asked what happened and stated resident 2 pushed her. The staff member notified the nurse.

During an interview, the nurse stated staff notified them by walkie-talkie that they found resident 1 on the floor, crying and in pain. The nurse assessed resident 1 and noted after lifting her off the floor, resident 1 limped and dragged her right leg. The nurse contacted resident 1's hospice provider who ordered an x-ray and pain medication.

During an interview, an administrative staff stated the x-ray determined resident 1's hip was fractured. The facility initiated an investigation of resident 1's fall, during which they reviewed

surveillance video. The administrative staff stated the camera from inside the sunroom showed resident 2 pushed resident 1 and there had been no physical contact between the two prior to that. The administrative staff stated resident 2 did not have early warning signs before aggressions and confirmed with family that was true of resident 2 prior to admission as well.

During investigative interviews, multiple staff stated resident 2 had aggressive episodes when staff tried to provide services that required hands on. The staff members stated the service plan directed staff to go slowly, explain, and give resident 2 time to process. The staff members stated resident 2 had been aggressive with peers who touched her, but did not target any specific peer, did not push a peer down before this incident, and her aggression could be unpredictable.

During an interview, a family member stated resident 1 had been at the facility for several years and had enrolled in hospice months before as her Alzheimer's symptoms worsened. The family member stated resident 1 remained on comfort cares and passed away about three weeks after the incident.

Resident 1's death record indicated the cause of death was complications of a hip fracture as a consequence of a push and fall to the floor.

A review of recorded video surveillance from the incident showed two staff walked a resident down the hall and into their room. The video showed resident 2 and a male peer walked right behind the staff. Resident 2 and the male resident then wandered into the sunroom and the male peer sat down at a table. The video showed resident 1 entered the sunroom shortly after and resident 2 walked toward resident 1 pointing toward the door. At no time during the video did resident 1 touch resident 2. The video had no sound but showed resident 2 mouthed what appeared to be "no" or "go" and pointed again toward the door while looking at resident 1. The video showed resident 1 turned away and walked toward the doorway. Resident 2 took a few steps toward her and pushed resident 1 from behind, which caused resident 1 to fall. The time between when resident 1 entered the room until resident 2 pushed resident 1 was about one minute.

Law enforcement indicated they were investigating the incident.

In conclusion, the Minnesota Department of Health determined 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 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.

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility investigated the incident, made program changes which included moving activities off the locked memory care unit, and providing meals on the memory care unit for some residents to decrease stimulation. Resident 2's doctor made medication changes.

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

Washington County Sheriff's Department

Washington County Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33881	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/30/2024
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NAME OF PROVIDER OR SUPPLIER GOOD LIFE ASSISTED LIVING & ME	STREET ADDRESS, CITY, STATE, ZIP CODE 5260 127TH STREET NORTH HUGO, MN 55038
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(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	<p>Initial Comments</p> <p>On April 30, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL338813386C/#HL338813281M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____