Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343206003M
Compliance #: HL343208685C

Date Concluded: February 7, 2025

Name, Address, and County of Licensee Investigated:
Mill City Senior Living
1520 17TH Street NW
Faribault, MN 55021
Rice County

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

Evaluator's Name: Deb Schillinger, RN BSN
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 the resident when meals were not provided in room per care plan.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a change in her care plan from meal delivery to escort assistance to meals although the communication plan for this transition took some adjustment to implement. The facility instructed the unlicensed caregivers to offer escort to the meal and, if refused, to offer a meal tray. After initial implementation, the facility made an adjustment in the plan included that if the meal tray was refused, the unlicensed caregivers were to offer an Ensure drink (meal replacement).

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 record, death record, hospital records, facility

internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between residents and staff during an onsite visit.

The resident resided in an assisted living facility unit. The resident's diagnoses included Lambert-Eaton syndrome (an auto-immune disorder that causes muscle weakness) and skin breakdown. The resident's service plan included assistance with medication management and assistance with activities of daily living including dressing, bathing, and toileting. The resident's assessment indicated the resident used a wheelchair for mobility, frequently refused care and services from facility caregivers and was cognitively impaired. The resident also received care from an outside home health care service for wound care.

One weekend, a concern arose that the resident did not receive food from the facility for four days after care plan changes were made that changed from "meal tray delivery" to "escort assist" on unlicensed caregiver's task list.

An additional concern arose that the resident's brief was often soiled and was not having bowel movements or urine output.

Saturday
The resident's medical record indicated that for breakfast and lunch the resident received meal trays in her room, and for the evening meal the resident went to the dining room.

The same document indicated the resident received "Toileting/Incontinent Assist" six times and refused two times.

Sunday
The resident's medical record indicated that for breakfast and lunch, the task notes indicated "was told we are not doing meal deliveries anymore after moving downstairs", and the evening meal task was documented as completed with a note stating "brought her a room tray"

The same document indicated the resident received "Toileting/Incontinent Assist" six times and refused care three times.

Monday
The resident's medical record had no documentation of breakfast. For lunch, a note indicated "Does not get meal delivery" and for the evening meal it was documented that the resident refused.

A progress note indicated the resident was out with the family member around the noon mealtime. After the resident returned from this outing, the facility identified a skin tear and sustained a skin tear to her left hand returning to the facility.

The same document indicated the resident received “Toileting/Incontinent Assist” six times, was out of the building for the before lunch task and refused cares two times.

Tuesday
The resident’s medical record indicated that for breakfast the meal was refused, lunch indicated a note “not supposed to say delivering anymore”, and the evening meal task was changed to "escort assist" changed from " Meal tray delivery" and documented the resident refused the evening meal.

The same document indicated the resident received “Toileting/Incontinent Assist” seven times and refused care two times.

A progress note indicated the medical provider was updated of the situation, and an order was obtained to provide an Ensure if the resident refuses a meal.

Wednesday
The resident’s medical record indicated that for breakfast the escort to the dining room was refused, lunch indicated a note “refused – did not want to go and meal tray brought in by nurse”, and the evening meal task was refused with a note “staff brought in meal tray”.

The same document indicated the resident received “Toileting/Incontinent Assist” six times and refused care three times.

The resident’s progress notes indicated the facility provided education regarding safety risks of eating meal alone in room and refusal of incontinent care, which may lead to skin breakdown.

During an interview, a nurse stated a conversation was held with the resident and family member regarding concern for the resident’s safety while eating alone in her room and the increased need for assistance with cares. The nurse stated the facility offered the option of the resident moving to an area in the facility with a higher staffing ratio, so the resident’s needs could be better met. It was explained the resident then would be escorted to the dining room by staff to eat meals or the resident could be served a meal to take back to her apartment.

During the same interview, the nurse stated the resident was not denied food, although the resident did refuse some meals. The nurse stated the resident had a “snack box” provided by family with the resident’s favorite snacks and was provided Ensure when the resident refused meals. The nurse stated a meeting was held with the resident, the resident’s family, and the facility to address these concerns with the outcome the facility caregivers would continue to encourage the resident to attend meals in dining room, however if the resident refused to go to the dining room, a meal tray would be provided.

During an interview, unlicensed staff member #1 stated the resident was encouraged to go to the dining room for meals for safety and socialization. Caregiver #1 stated when the resident refused meals, the staff did not deny her food and the resident always had snacks and Ensure available to her.

During an interview, unlicensed staff member #2 stated she received instructions to wake the resident up at mealtime and offer to assist her to the dining area where she could eat her meal or take the meal back to her room. Caregiver #2 stated the resident was able to make her needs known and facility staff would not have denied food to the resident. Caregiver #2 stated there was not a time where the resident was left in her room and denied food for several days.

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.
(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, resident is deceased

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

Action taken by facility:
No action required

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
	34320	A. BUILDING: _____ B. WING _____	C 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CITY SENIOR LIVING	1520 17TH STREET NW FARIBAULT, MN 55021

(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 January 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL343208685C/#HL343206003M . No correction orders are issued.	0 000		