Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52157726M
Compliance #: H52154124C

Date Concluded: March 7, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Lakeshore
4002 London Rd.
Duluth, MN 55804
St. Louis County

Facility Type: Nursing Home

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

Finding: Substantiated, individual responsibility

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 resident was neglected when the alleged perpetrator (AP) transferred the resident into the bathroom, then left the resident unattended. The resident fell and sustained a hip fracture requiring treatment at the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP transferred the resident to the toilet and left the resident unattended. The resident fell, reported pain to the AP, and asked the AP to get help, but the AP refused. The AP made the resident walk to the bed from the bathroom despite the resident reporting pain. The resident was transferred to the emergency department (ED) and diagnosed with a hip fracture requiring hospitalization and surgical repair.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The

investigation included review of the resident record(s), hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, prior federal investigation documents, and related facility policy and procedures.

The resident resided in a nursing home with diagnoses including cerebral vascular accident (stroke), cognitive deficit following stroke, hemiplegia/hemiparesis (paralysis on one side of the body) affecting the left side, difficulty walking, and muscle weakness.

The resident's assessment indicated the resident required extensive physical assistance from one staff with transfers, toileting, and personal hygiene. The assessment identified the resident was not steady and only able to stabilize with staff assistance.

The resident's care plan indicated the resident had balance impairment, left sided weakness, and forgetfulness related to a recent stroke. The care plan identified the resident was at risk for falls and indicated the resident required physical assistance from one staff with transfers and toileting. The care plan indicated the resident had impaired thought process related to stroke and instructed staff to cue, orient, and supervise the resident. The care plan identified the resident utilized sedative and antidepressant medications which could increase drowsiness, confusion, dizziness, balance problems, and risk for falls.

The resident's Kardex indicated the resident was alert and oriented with some forgetfulness. The Kardex indicated the resident required extensive physical assistance from one staff and a walker for transfers and toileting. The Kardex instructed staff to notify the nurse of any falls or unexpected changes in position.

The resident's progress notes indicated the resident was admitted to the facility for mobility deficits following a stroke with left sided hemiparesis. The progress note indicated the resident underwent surgery for reconstruction of squamous cell carcinoma. During the post op period the resident suffered a right sided stroke causing left sided functional deficits. The progress note indicated the resident was assessed and required physical assistance from staff with all mobility and transfers. A fall incident note six days later indicated the resident was using a urinal in the bathroom and fell. The note indicated the AP was not in the bathroom with the resident at the time the fall occurred. The resident complained of left hip pain and was transferred to the hospital.

A post hospital after visit summary (AVS) indicated the resident was admitted to the hospital for surgical repair of a closed hip fracture after sustaining a fall at the facility.

The facility investigation indicated the AP neglected the resident when she failed to follow the resident's plan of care to maintain contact and supervision with the resident during transfers and toileting. The facility investigation indicated the AP failed to follow proper fall protocol to report the fall and have the resident assessed for injuries prior to moving the resident. The facility investigation indicated the AP verbalized understanding of how to report a fall. However,

the investigation indicated the AP did not call for assistance or report the fall because the resident “did not verbalize pain or ask her to get help”. The investigation indicated when interviewed the resident stated the AP transferred him to the toilet then left him alone and sat on a recliner outside the room. The resident stated he transferred himself off the toilet to the sink to wash his hands, felt the urge to urinate again, and reached for the urinal alongside the toilet and, “down I went”. The resident stated he reported pain to the AP immediately, and told the AP to get help, but the AP repeatedly pulled on him and said “No, I’ll get you up” and continued pulling on him. The resident stated he grabbed the bar by the sink, but “it hurt to move”. The resident stated the AP got him back onto the toilet, applied a transfer belt, then had him use his walker to walk back to bed. The resident expressed difficulty getting back to bed because “his leg was in so much pain and he could barely move it”. A statement from an unlicensed personnel (ULP) indicated the AP was casually walking down the hallway and reported the resident fell in the bathroom. The ULP statement indicated the AP and resident reported the resident fell while using his urinal independently in the bathroom. One nurse’s statement indicated the AP reported she was with the resident when he became unsteady, then the AP lowered the resident to the ground. The nurses statement indicated the resident was asked if the AP lowered him to the floor, and the resident said “No”. Several nurse’s statements indicated the resident consistently reported the AP transferred the resident into the bathroom without a transfer belt then left the resident unattended. The nurse statements indicated the resident reported pain to the AP, and told the AP to get help, but the AP refused, then the AP moved the resident before he could be assessed for injuries. The facility investigation identified the AP had inconsistent statements about the incident.

A review of the AP’s personnel files included completion of education and training on mobility, safe transfers, ambulation, falls, and documenting/reporting resident changes.

The AP’s statement following the incident indicated the AP was exiting the bathroom with the resident when the resident had an urge to urinate more. The AP statement indicated she assisted the resident to use his urinal, then sat on the edge of the chair for a moment, and the resident fell. The AP statement indicated she assisted the resident off the floor onto the toilet, then transferred the resident back to bed.

When interviewed facility leadership stated the AP failed to provide assistance needed, as a result the resident fell and sustained a serious injury. Leadership staff stated the AP should have had a transfer belt on the resident and maintained continuous contact in case of sudden weakness or instability. Leadership staff stated after the fall, the AP transferred the resident to the toilet, then made the resident walk back to his bed before notifying nursing staff. Leadership staff stated the AP was trained, competent, and verbalized knowing what assistance the resident needed, and how to report/respond to a fall after the fall incident occurred.

When interviewed several nursing staff stated the AP had inconsistent statements after the incident occurred including initially reporting she was in a recliner outside the bathroom when the resident fell, then stated she lowered the resident to the floor, then told another staff she

used a mechanical standing lift to transfer the resident from the toilet to his bed. When interviewed nursing staff stated the AP appeared defensive and tried to talk over the resident when the resident was telling nursing staff what happened, and the AP was asked to leave the room so the resident could speak. Staff stated the resident reported the AP sat on a recliner outside the bathroom, the AP was not in the bathroom assisting him when he fell, and the AP did not lower him to the floor. Staff stated the resident reported having pain to the AP, told the AP to get help, but the AP refused and transferred him to the toilet, then made him walk to his bed. Staff stated the resident was a reliable reporter, and no mechanical lift was present in or near the resident's room at the time of the incident indicating the resident had walked to his bed from the bathroom with a fractured hip as directed by the AP.

When interviewed therapy staff stated anytime a resident required physical assistance from staff the resident should have a transfer belt on and maintain contact with the resident. The therapy staff stated the resident had problems with left sided weakness and balance related to a recent stroke and required hands on physical assistance from staff to stabilize with transfers, standing, and toileting. The therapy staff stated it was not appropriate for the AP to leave the resident unattended, and explained any time the resident needed to remove his hands off the walker to use or grab his urinal would have increased his instability and risk for falls. The therapy staff stated the AP was seated in the recliner outside the bathroom and would not have been able to observe the resident because the bathroom door obstructed the view. The therapy staff stated the resident was a reliable reporter.

During interview the resident and resident's family member stated at the time of the incident the AP was seated on a recliner chair outside the bathroom about 5 feet away from the resident when he fell. The resident stated he immediately reported pain to the AP and told the AP to get help because he could not get up, but the AP said "no!" The resident stated the AP repeatedly pulled on him while persistently demanding, "get up, stand up, get up!" Despite the resident reporting pain. The resident stated the AP did not want to call for help because she knew she was in trouble and was trying to cover her tracks.

The AP refused to be interviewed regarding the incident and indicated she would provide a written statement. The AP was instructed to fax the statement, no statement was received.

In conclusion, the Minnesota Department of Health determined 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 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, refused.

Action taken by facility:
The facility assessed the resident for injuries, then transferred the resident to the hospital for evaluation and treatment. The facility suspended the AP pending an investigation, reported the incident to the common entry point Minnesota Adult Abuse Reporting Center (MAARC), investigated the incident, and provided education to staff to prevent recurrence. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

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
St. Louis County Attorney
Duluth City Attorney

Duluth Police Department
Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 55804

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H52157726M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 H52157726M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure one of one resident (R1) was free from maltreatment. The findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		