Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53489365M
H53489310M/H53489289M/H53489309M
Compliance #: H53486623C
H53486569C/H53486521C/H5348657C

Date Concluded: February 13, 2024

Name, Address, and County of Licensee Investigated:
The Estates at Rush City
650 S Bremer Ave,
Rush City, MN 55069
Chisago County

Facility Type: Nursing Home

Evaluator's Name: Brandon Martfeld, 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.

Initial Investigation Allegation(s):
The alleged perpetrated (AP), facility staff, neglected the residents when the AP left her shift early leaving Resident #1, Resident #2, Resident #3, and Resident #4 unsupervised.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP left her shift early, other facility staff provided the supervision and care according to the resident's care plans. Facility management arranged for staff to cover the remainder of the AP's shift that evening.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and certified staff. The investigator also completed interviews with multiple family members and the alleged perpetrator. The investigation included review of the residents' records, facility incident reports, personnel files, and staff schedules.

Resident #1 resided in a nursing home. Resident #1's diagnoses included schizophrenia, diabetes, dysphagia (swallowing difficulties) and anxiety. Resident #1's care plan indicated the resident had a mechanical soft diet (a diet designed for people who have trouble chewing and swallowing) and was at risk for neglect. Resident #1 had intact cognition and required assistance with toileting, showering, dressing, and personal hygiene.

Resident #2 resided in a nursing home. Resident #2's diagnoses included weakness and failure to thrive. Resident #2's care plan indicated the resident transferred with a stand lift, received hospice services for end-of-life care and was at risk for neglect. Resident #2 required assistance with toileting, showering, dressing and had moderate impaired cognition.

Resident #3 resided in a nursing home. Resident #3's diagnoses included dementia and anxiety. Resident #3's care plan indicated the resident received hospice services, was at risk for falls, and had a mechanical soft diet with thickened liquids because of swallowing difficulties. Resident #3 was severely cognitively impaired and required total assistance with eating, toileting, showering and dressing.

Resident #4 resided in a nursing home. Resident #4's diagnoses included Alzheimer's disease and anxiety. Resident #4's care plan indicated the resident was non-verbal, received hospice services, had a mechanical soft diet, thickened liquids, was at risk for falls and neglect. Resident #4 was severely cognitively impaired and dependent on staff to complete activities of daily living.

During an interview, a nurse stated she was working with the AP the evening of the incident. The nurse was notified that the AP had left the facility. The nurse stated she looked for the AP, but the AP was gone. The nurse stated after the AP left, the facility was staffed with another nurse and one aide. The nurse stated there were no emergencies, resident cares were provided and within 30 minutes another staff member arrived at the facility to finish out the AP's evening shift.

During an interview, another nurse stated she received communication from the facility while at home that the AP left around dinner time. The nurse said the facility requested she come to the facility to help for the remainder of the shift. The nurse stated when she arrived at the facility, there was two nurses and one nursing assistant completing cares for the residents.

During an interview, a third nurse stated there was approximately 30 residents at the facility at the time of the incident. The nurse stated when the AP left her shift early, the facility was adequately staffed to assist the residents with cares and supervision.

During an interview, the AP denied leaving her shift early without notifying leadership.

During an interview, multiple family members of the residents did not express concerns with cares during 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. Multiple unsuccessful attempts were made to contact Resident #1. Resident #2 and Resident #3 were deceased, and Resident #4 was not able to communicate.
Family/Responsible Party interviewed: Yes. Resident #1 was his own responsible person. Contacted family for Resident #2, Resident #3, and Resident #4.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility had staff available to work the remaining hours the AP left early. The facility completed disciplinary action with the AP and the AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, 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.

You may also call 651-201-4200 to receive a copy via mail or email.

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.

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
	00994	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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 #H53489365M/#H53489310M/#H53489289M/#H53489309M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		