Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200113161M
Compliance #: HL200113222C

Date Concluded: September 4, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Worthington
1801 College Way
Worthington, MN 56187
Nobles County

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

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when the facility failed to ensure appropriate follow-up care was provided for a resident who hit his head during a fall. Later the same day, the resident was unresponsive and sent to the hospital where he passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had a history of chronic blood thinner use, and after the resident fell he told staff he hit his head during the fall. The resident was unable to be aroused by staff later that same day and emergency services were contacted to transport the resident to the hospital. The resident was diagnosed with a subdural hemorrhage (a type of bleeding in the head that us usually caused by serious head injuries and can be lift threatening) and died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident ‘s medical records, death record, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff members interacting with residents.

The resident resided in an assisted living facility with diagnoses including Parkinson’s disease, long term use of blood thinner, and mild cognitive impairment. The resident’s service plan included assistance with transferring and toileting. The resident’s assessment indicated he was at high risk for falls, tired easily with any effort, used a four wheeled walker, and needed the physical assist of one person for toileting.

Review of the fall incident report indicated the resident had a fall in the early morning hours. The resident was alone in the bathroom while a staff member was picking out clothing for the resident. The report indicated the resident hit his head, sustained a skin tear, and was transferred back to bed and made comfortable. In the evening, the resident went to the emergency room for a change in level of consciousness.

The residents progress notes, entered by a nurse approximately four hours after the fall, indicated an unlicensed personnel member contacted the on-call nurse approximately thirty minutes after the residents fall to report the incident. The note indicated the resident had a skin tear to his right arm, usual range of motion and was “aware and alert, acting his usual self. No other changes or concerns at this time.” The nurse wrote, “Instructed caller to call the nurse back for questions or changes. Caller verbalizes understanding and denies any other needs. Plan of care ongoing.”

Progress notes from approximately eighteen hours after the fall indicated an unlicensed staff contacted the on-call nurse to report the resident was transferred to the hospital due to a change in level of consciousness.

Review of the resident’s hospital record indicated the resident was diagnosed with traumatic subdural hemorrhage with loss of consciousness and compression of the brain. The record indicated the resident was unresponsive, had snoring respirations and dried blood in his mouth. Due to likelihood of a very poor outcome, surgery was not recommended. The resident was placed on comfort care and died.

Review of the resident’s death record indicated the resident’s immediate cause of death was complications of closed head injury due to a fall to floor.

During interview, an unlicensed staff stated the resident was in the bathroom and she was in the closet next to the resident’s bathroom when she heard a loud noise. The unlicensed staff went into the bathroom, saw the resident on the floor and called a co-worker to assist. The resident did not know how he fell and stated he was not hurt, but that he hit his head, and the resident had a skin tear on his arm. The unlicensed staff completed a facility incident report and

contacted the on-call nurse. The on-call nurse instructed the unlicensed staff member to call back with any concerns.

During interview, a second unlicensed staff stated he was called by a co-worker to assist the resident after a fall. The resident was, “shaken-up,” and reported hitting his head. The second unlicensed staff stated he did not know if the resident was on blood thinners and did not know if there would be additional concerns regarding a resident hitting their head when taking blood thinners.

During interview, a nurse stated she received a call in the early morning hours from a staff and was told the resident fell while in the bathroom and sustained a skin tear. Staff reported the resident’s range of motion was normal and he was awake and alert. The nurse directed staff to contact the on-call service if there were any changes and the nurse stated she did not enter any extra checks or monitoring services into the resident’s record. The nurse stated she did not recollect information outside of a progress note she wrote in the resident’s chart and did not recollect if there was anything concerning that would have warranted further consideration regarding the resident. The nurse stated on-call nurses have access to resident medical records, including medications and services.

During interview, a third unlicensed staff stated she was assigned to the resident during the afternoon hours after the fall and saw a note regarding the resident’s fall during the morning hours and that the resident progressed through his day as he normally did. The unlicensed staff stated the resident typically went to bed for a bit during the day, but that he did not call for assistance to get out of bed in the afternoon as he usually did. The unlicensed staff checked on the resident and he was snoring and appeared to be in a deep sleep. During suppertime, the resident still was not up, which was unusual. The hour after supper the unlicensed staff stated the resident would not get up and was still snoring. The staff stated she and another staff member tried to sit the resident up in bed, but he would not open his eyes. The staff member stated she contacted the nurse and was instructed to call for an ambulance.

During interview a second nurse stated the facility was attempting to make sure that residents are sent to the hospital for follow-up care when a resident hits their head or has a fall when taking blood thinners.

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: No, resident deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted an internal review of the incident.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in 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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Nobles County Attorney
Worthington City Attorney
Worthington Police Department
Ramsey County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20011	A. BUILDING: _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN WORTHINGTON THE MEADOWS	1801 COLLEGEWAY WORTHINGTON, MN 56187

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL200113222C/#HL200113161M, #HL200113470C/HL200113322M On July 15, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 100 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL200113222C/#HL200113161M and #HL200113470C/HL200113322M , tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment reports for details.	02360	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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Request for Reconsideration received