

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201145703M
Compliance #: HL201149919C

Date Concluded: August 23, 2023

Name, Address, and County of Licensee

Investigated:

Ecumen Lakeview Commons
1200 North Lakewood Drive
Maplewood, MN 55119
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Inconclusive

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):

Unknown facility staff neglected a resident when they provided hot coffee that scalded the resident's mouth and lips.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. The resident was found with dark discoloration of her lips and tongue. Initially the facility registered nurse and hospice registered nurse thought the resident was burned with coffee. Following a facility investigation, it was determined the resident may have bled internally due to the resident's diagnosis of thrombocytopenia (a condition that occurred when the platelet count in your blood is too low causing bleeding.)

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice medical director, the county medical examiners, the hospice nurse and family members. The investigation included

review of facility medical records, hospice medical records, death certificate, pictures of the resident, facility internal investigation, facility schedules, and policies, and procedures. Also, the investigator made an onsite visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and thrombocytopenia. The resident's service plan included assistance with oral care, grooming, bed mobility, safety checks, meal tray delivery, setup, and assistance with eating. The resident was bedridden, did not transfer out of bed, and was under the care of hospice and facility staff. The resident required staff to anticipate her needs.

The hospice notes from the day of incident indicated the "patient [resident] may have received too hot of coffee after telling staff to microwave it for three minutes and her entire mouth is burned." The hospice notes indicated the resident was unable to rate her pain level, however, the note indicated the resident had moderate pain. The note indicated the "patient' [resident's] outer lips were burned as well as the inner mouth and tongue." The hospice note indicated the resident's lower lip was necrotic (death of cells or tissue through disease or injury) and the entire lip and mouth was bloody with the upper lip necrotic with scabs.

The facility's incident report indicated one morning the resident was found lying in bed with lip and tongue discoloration. The resident's lips were dry, flaky, and purple/black in color. Facility staff had observed the resident picking on her mouth, lips, and tongue with bleeding.

The facility investigation indicated the day of the incident the resident's lips and mouth were purplish brown in color. The resident's upper and lower lip appeared dry and flaky. The resident's tongue had a nickel size blackish brown discoloration on the left side. The remainder of the resident's mouth was red in color. The resident enjoyed coffee and according to the hospice nurse, had asked a nurse practitioner earlier in the week to heat coffee in the microwave for three minutes. The nurse practitioner did not heat the coffee as requested. The facility report indicated no coffee was observed at the resident's bedside and no staff reported serving the resident coffee.

The report indicated the hospice medical director and the resident's primary care physician indicated the resident had scabbing from internal bleeding and the discoloration around the lips was dried blood. The resident was unable to report the cause of discoloration. The resident denied pain and was observed rubbing a washcloth against her lips without facial grimacing.

Review of multiple pictures of the resident's face revealed the upper and lower lips were dry, flaky, with a dark discoloration of the resident's lips, mouth, and tongue. Portions of the upper lip not discolored was pale pink in color. There was no swelling, redness, or blisters to the resident mouth, lips, tongue, chin, neck, or chest.

During an interview, the facility nurse stated the resident had started to shake more due to a decline in her health. The nurse stated, staff had not provided coffee for three or four days prior

to the incident because of burning concerns. The nurse stated none of the staff reported heating or serving the resident hot coffee. The hospice nurse assumed facility staff gave the resident hot coffee because the resident had previously requested hot coffee. The nurse stated pictures were taken of the resident's mouth and sent to the hospice medical director. The resident did not have any other markings outside of her mouth, nothing on her chest, or neck. The resident passed away less than 24 hours later.

During an interview, unlicensed staff member (ULP), stated in the final days the resident was not eating or drinking.

During an interview, the hospice nurse stated the morning of the incident, the resident appeared to have burns on her lips and inside of her mouth. Initially, the hospice nurse and facility nurse thought facility staff warmed up the resident's coffee in a microwave and the resident drank it. The hospice nurse stated the hospice medical director, said the resident bled from her mouth. The hospice nurse stated the resident had no other areas on her body that looked burned. The resident passed away within 24 hours of the incident.

During an interview, the hospice medical director stated the hospice nurse made a "speculation" because earlier the resident had asked the nurse practitioner for hot coffee. The hospice medical director stated the appearance of the resident's mouth could be explained because the resident had thrombocytopenia and was prone to a gastrointestinal (GI) bleed.

During an interview, the family member stated the resident needed assistances with eating because she was weak and shaky. The hospice nurse thought her mouth was burned because of coffee. The family member took pictures of the resident's mouth.

The death certificate indicated the resident's cause death was from complications of oral scalding. Other significant conditions that contributed to the resident's death was thrombocytopenia and dementia.

During an interview, the county medical examiner stated the resident's death was determined from a review of the resident's medical records and pictures of the resident's face.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility notified the hospice nurse and physicians. The resident's diet was changed to liquids, ice cream and applesauce. Facility staff placed a do not use sign on the resident's microwave. New physician orders for pain management and treatments for burns were obtained. The facility also completed an internal investigation.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2023
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NAME OF PROVIDER OR SUPPLIER ECUMEN LAKEVIEW COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH LAKEWOOD DRIVE MAPLEWOOD, MN 55119
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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 August 14, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL201145703M/#HL201149919C. No correction orders are issued.</p>	0 000		

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