Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204517766M
Compliance #: HL204514574C

Date Concluded: October 17, 2023

Name, Address, and County of Licensee Investigated:
Pearl Garden
3700 Foss Road Northeast
St. Anthony, MN 55421
Hennepin County

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

Evaluator's Name: Nicole Myslicki, 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 resident fell and hit her head, and the facility did not send her to the emergency department until hours later when the resident became unresponsive. Subsequently, the resident was diagnosed with a traumatic brain injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to contact the resident's physician immediately after the fall due to the resident being on a blood thinner and hitting her head. The facility waited approximately five hours after the fall to send the resident to the hospital when the resident became unresponsive. The resident died the next day after her fall due to a significant brain bleed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included

review of the resident's medical record, policies including vulnerable adult, falls and emergencies and incident reports. Also, the investigator observed staff interactions with residents, transfers, and toileting.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and long-term use of an anticoagulant (a medication used to treat or prevent blood clots). The resident's service plan included assistance with safety checks and medication administration. The resident's assessment indicated the resident toileted and walked without assistance from staff. The resident's physician orders included warfarin (an anticoagulant) 4 milligrams (mg) Sunday, Tuesday, Wednesday, Friday, and Saturday, and warfarin 5 mg Monday and Thursday.

An incident report indicated the resident pushed her pendant in the middle of the night. A staff member entered the room and found the resident laying on her left side on the bathroom floor. The staff member observed a small bump on the left side of the resident's head. The resident stated she used the toilet and tried to get out of the bathroom when she fell. The staff member assisted the resident off the floor and administered acetaminophen (a pain-relieving medication) and provided an ice pack per the resident's request. The staff member notified the on-call registered nurse (RN). The facility staff failed to contact the resident's physician to provide notification of the fall and obtain instructions. Facility staff checked on the resident several times and did not note a change in condition. The resident talked with a day shift staff member approximately four hours after the fall, appearing alert and resting on a couch. Thirty minutes later, a RN went to assess the resident and found the resident no longer responding to stimuli. The facility staff called 911, and emergency medical services (EMS) transported the resident to the emergency department (ED).

EMS records indicated the resident arrived to the ED approximately five hours after her fall. The resident remained unresponsive and did not respond to painful stimuli. These records indicated the resident had swelling on the back of her skull, approximately two inches in diameter, and the area had previously been bleeding externally. The resident's hair had matted to where the bleeding had been coming from.

The resident's hospital record indicated the resident presented with a large bleed in her head after the fall and decreased consciousness. An ED physician evaluated the resident and determined she had a high probability of imminent life-threatening deterioration due to the severe subdural hemorrhage (brain bleed) with coma. A neurosurgery physician examined the resident and determined no neurosurgery was indicated due to the nonsurvivable bleed and do not resuscitate (DNR) status. Family pursued comfort cares, and the resident died the next day.

The resident's death certificate identified a brain bleed due to a fall as the cause of death.

During an interview, a nurse stated the overnight unlicensed personnel (ULP) called to report the resident fell but did not recall there being any issues at the time of the fall.

During an interview, a management staff person stated she completed an internal investigation of the incident and spoke with the ULPs on duty and the nurse on call at the time of the fall. The overnight ULP who found the resident on the floor followed protocol and notified the on-call nurse, updating the nurse about the fall. The ULPs checked on the resident multiple times after the fall, and the resident seemed fine. Since this incident, the facility completed reeducation with all nursing staff regarding the fall emergency protocol, when to call 911, and what to report to the on-call nurse.

During an interview, a family member stated the resident had been fairly independent prior to the fall. The resident did not require a lot of assistance from staff. The resident called the family member approximately three hours after her fall. The resident informed the family member she fell and hit her head, and staff gave her an ice pack but did not come back to check on her after. About an hour later, a morning shift ULP called the family member while walking to the resident's room. The family member could hear the resident talking in the background during the call. Approximately 30 minutes later, the family member received a call from a nurse, informing her the resident lost consciousness and needed to go to the hospital. At the hospital, the physician informed the family member there was nothing they could do for the resident. The family member stated she wished the facility would have called 911 right away after the fall because the resident had been on an anticoagulant. The family member stated she wondered if the resident would have had a chance to live if the facility would have called 911 right away.

A North American Thrombosis Forum web article titled Falls and Anticoagulation: What You Should Know, updated July 17, 2023, indicated if one falls while on a blood thinner, the healthcare provider should be contacted right away. The article indicated bleeding is not always visible and internally bleeding could occur without one knowing it, which poses a significant concern when people fall and hit their heads.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an internal investigation. The facility updated their fall and emergency protocol and educated staff.

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
Hennepin County Attorney
Saint Anthony City Attorney
Saint Anthony Police Department
Hennepin County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20451	A. BUILDING: _____ B. WING _____	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL GARDEN	3700 FOSS ROAD NE MINNEAPOLIS, MN 55421

(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: #HL204514574C/#HL204517766M On August 15, 2023, 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 23 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for ##HL204514574C/#HL204517766M, tag identification 2310, 2360.	0 000	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.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to contact the physician and timely send one of one residents (R1) to the hospital following a fall with head strike while on an anticoagulant.Approximately five hours after the fall, R1 became unconscious, went to the hospital and died due to severe head bleeding. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: A North American Thrombosis Forum web article titled Falls and Anticoagulation: What You Should Know, updated July 17, 2023, indicated if one falls while on a blood thinner, the healthcare provider should be contacted right away. The article indicated bleeding is not always visible and internally bleeding could occur without one knowing it, which poses a significant concern when people fall and hit their heads. R1 admitted to the licensee October 30, 2020. R1's diagnoses included long-term use of anticoagulants and dementia. R1's service plan dated November 1, 2022, indicated R1 received	02310		

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02310	Continued From page 2 assistance with safety checks and medication administration. A nursing assessment dated August 31, 2022, indicated R1 toileted and walked independently. R1's physician order signed September 13, 2022, indicated R1 received warfarin 4 milligrams (mg) Sunday, Tuesday, Wednesday, Friday, and Saturday, and warfarin 5mg Monday and Thursday. An incident report dated November 4, 2022, indicated R1 pushed her pendant at 3:30 a.m. unlicensed personnel (ULP)-F entered the room and found R1 laying on her left side on the bathroom floor. ULP-F observed a small bump on the left side of R1's head. R1 stated she used the toilet and tried to get out of the bathroom when she fell. ULP-F assisted R1 off the floor, administered acetaminophen and provided an ice pack per R1's request. ULP-F notified on-call registered nurse (RN)-A. ULP-F and ULP-G checked on R1 several times and did not note a change in condition. At 7:30 a.m., R1 talked with ULP-C who appeared alert and resting on a couch. At 8:00 a.m., RN-H went to assess R1 and found R1 no longer responding to stimuli. Staff called 911, and emergency medical services (EMS) transported R1 to the emergency department (ED). R1's record lacked documentation of communication with R1's physician regarding a head strike fall while on warfarin and to obtain further instructions. R1's hospital record indicated R1 presented with a large subdural hematoma after the fall and decreased consciousness. An ED physician evaluated R1 and determined she had a high	02310		

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02310	Continued From page 3 probability of imminent life-threatening deterioration due to the severe subdural hemorrhage with coma. A neurosurgery physician examined R1 and determined no neurosurgery was indicated due to the nonsurvivable hemorrhage and do not resuscitate (DNR) status. Family pursued comfort cares, and R1 died November 5, 2022, at 10:47 a.m. R1's death certificate identified R1's cause of death as a subdural hematoma due to the fall. During an interview on August 15, 2023, at 12:40 p.m., ULP-I stated, in general, calling 911 for a fall with head strike would have depended on the severity, or if the nurse decided to call. During an interview on August 15, 2023, at 1:20 p.m., ULP-J stated if a resident fell and hit their head, the on-call nurse would have either come in and assessed the resident or told staff to call 911. During an interview on August 15, 2023, at 2:11 p.m., RN-K stated the on-call nurses did not have access to resident records at home. After this incident, with any head strike, residents were be sent in or family would be called to see if they wanted staff so send them in. During an interview on August 15, 2023, at 2:39 p.m., RN-K stated the licensee did not have a procedure for the on-call nurses to follow. The licensee-provided document Fall/Emergency Protocol, undated, indicated when a staff person observed a resident on the floor, they should provide the on-call nurse with accurate information including whether the resident hit their head. Additionally, this document identified having a head strike or a lump or bump on the	02310		

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02310	Continued From page 4 head as circumstances which warranted notification of 911. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		
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 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was 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 report for details.	02360	No plan of correction is required for this tag.	