Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215681941M
Compliance #: HL215683483C

Date Concluded: October 20, 2022

Name, Address, and County of Licensee Investigated:

PioneerCare Memory Cottages
1307 South Mabelle Avenue
Fergus Falls, MN 56537
Otter Tail County

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

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 a resident when they failed to immediately assess and arrange for an evaluation of the resident's condition following an unwitnessed fall. The resident died three days following the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Following an unwitnessed fall, the licensed nurse assessed the resident for injuries and provided for the resident's comfort. Approximately eight hours after the fall, the resident had a sudden change in condition and staff arranged for an evaluation at a hospital. The resident had a brain bleed, was discharged back to the facility with comfort care, and died three days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian. The investigation included review of the resident medical record, staff schedules, incident reports,

and facility policies and procedures including fall assessments. In addition, the investigator observed the facility and the resident's room.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, delusions, paranoia, and heart disease. The resident received long term blood thinner medication for an irregular heartbeat and pacemaker. The resident's service plan included staff supervision for grooming, bathing, and staff assistance with medication administration and meal preparation. The resident walked, toileted, and transferred without staff assistance. The resident was at a high risk for falls. The resident made her basic needs known but required others for decision making.

An incident report indicated one evening, the resident's roommate called out to staff for assistance with the resident. Staff found the resident in the bathroom, unsteady on her feet, and prevented a fall. Staff stayed with the resident for about ten minutes to ensure the resident's safety. About 20 minutes later, the resident's roommate called out for staff assistance for the resident. Staff found the resident laying on her stomach on the side of the bed with her head under the bed. The resident complained of pain "all over" and staff stayed with her until she agreed to be turned on her back but remain on the floor because "it hurt to be touched." Staff observed a cut and bump/bruise on the resident forehead and a "cut" to her right elbow. Staff contacted the on-call licensed nurse and obtained the residents vital signs. The resident first complained of pain in the back and hips, and then the resident said the pain was in her shoulders and legs. Staff placed a pillow under the resident's head and stayed with her until the licensed nurse arrived at the facility about one-half hour after the unwitnessed fall to assess the resident.

The resident was moving her extremities except for her left upper arm but was able to move her left wrist and fingers. Three staff used a Raiser brand mechanical lift to assist the resident into a sitting position. The resident was able to bear weight without complaint and talked to the staff without difficulty. The licensed nurse cleansed the residents right elbow cut and applied a bandage. Staff laid the resident in her bed and the resident stated she was comfortable. The resident's respirations were unlabored. An ice pack was placed on the resident's bump on her forehead and staff continued to check on the resident throughout the night.

About eight hours after the fall, staff checked on the resident, and she was making a "gurgling" noise when breathing. Staff contacted the on-call nurse, obtained vital signs, and arranged for the resident to be evaluated at a local hospital.

A progress note indicated the licensed staff completed a neurological assessment for the resident following the fall. The resident had equal movement and motion of her extremities.

The hospital record indicated the resident's diagnoses included a brain bleed and heart attack. The guardian made the decision to provide the resident with comfort care and the resident was transferred back to the facility the same day.

When interviewed an unlicensed personnel (ULP) stated she worked with the resident the evening of the fall and responded to the resident's roommate yelling for help. When entering the room, the resident was laying on her stomach on the floor next to her bed and with her head and face were under the bed. The resident thought she fell from the edge of the bed. Initially, with assist from another ULP, they were able to roll the resident on her back and remove her head from under the bed. The ULP contacted the licensed nurse who instructed them to leave the resident on the floor until she arrived at the facility. The ULP obtained the resident's vital signs and placed a pillow under the resident's head for comfort. After the licensed nurse assessed the resident, three staff assisted the resident to a sitting position using a Raiser brand lift. The ULP assisted the resident with changing clothes and once in bed placed an ice pack on the resident's bruised forehead. The ULP checked the resident during the night without concerns.

During an interview, the licensed staff stated she came in to assess the resident following staff finding the resident on the floor. The licensed nurse observed and examined the resident for injury and assisted two ULP's with a Raiser brand lift to get the resident into a sitting position. The resident was able to walk without complaints, able to grasp with both hands, move both arms and legs, and conversed at her normal level of functioning. The resident did not use her left shoulder but had no complaints of pain and the residents' vital signs were stable. When the resident was assisted in bed to lay down the resident commented that laying down felt good. The licensed nurse applied an ice pack to the cut and bump on the resident's forehead and cleaned and bandaged the cut on the resident right elbow. The licensed nurse instructed staff to check on the resident during the night and change the ice pack as needed. The resident normally slept through the night. When the day shift arrived the next morning to assist the resident's roommate, the resident's respirations had a "gurgling" sound and staff were not able to wake the resident. Staff contacted the licensed nurse, obtained vital signs, and arranged for the resident to be evaluated at a local hospital.

The resident's certificate of death indicated the resident died three days after returning to the facility with the cause of death listed as an intraventricular hemorrhage (bleeding in the spaces of the brain) following a fall.

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

Action taken by facility:
No action required.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	C 10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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 Initial comments On October 7, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL215683483C/#HL215681941M. No correction orders are issued.	0 000		