Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL232476825M
Compliance #: HL232472836C

Date Concluded: August 10, 2023

Name, Address, and County of Licensee Investigated:
Iris Park Commons
1850 University Ave West
St. Paul, MN 55104
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN
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, 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 provide appropriate care and services to prevent falls and subsequent injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. During the last week at the facility, the resident had a decline in health with increased weakness and unsteadiness. Following every fall, the facility nurse assessed, and implemented interventions to prevent future falls. Despite the interventions, the resident continued to fall and required hospitalization for a brain bleed.

The investigator conducted interviews with facility nursing staff, unlicensed staff, and the resident's family member. The investigator also interviewed the resident's medical provider. The investigation included review of the resident's medical records, hospital records, and facility policies and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, high blood pressure, coronary artery disease (this causes coronary arteries to narrow, limiting blood flow to the heart), and high cholesterol. The resident's service plan included assistance with dressing, toileting, and medication management. The resident's assessment indicated the resident was a high fall risk and walked independently with no devices. The resident's assessment indicated the resident had severe cognitive impairment.

The resident's medical record indicated the week prior to the hospitalization, the resident had increased weakness and difficulty walking. The facility implemented interventions that included the resident wore proper footwear, a toileting schedule, and placing the resident in common areas while awake for staff supervision. In addition, the facility provided the resident an in-house wheelchair for mobility when the resident had difficulty walking due to increased safety concerns with falls. During that time, facility staff requested a physical and occupational therapy referral from the resident's provider for an assessment. At the end of the week, facility staff assessed the resident for a change in condition including increased weakness and confusion. The resident's provider requested an evaluation of the resident at the hospital. The resident returned to the facility that same evening. One hour after returning, the resident had an unwitnessed fall in the dining room. The resident sustained a bump to his forehead and a skin tear to his wrist. The family chose to keep the resident at the facility because the resident had just been evaluated at the hospital.

Three days later, the resident had another unwitnessed fall with a cut to the resident's head at the eyebrow. The facility arranged for the resident to be evaluated at a hospital and the resident was diagnosed with a brain bleed. The resident remained at the hospital to arrange for a higher level of care. Eight days later, the resident passed away at the hospital with comfort care.

The resident's hospital record indicated the resident sustained a brain bleed following a fall at the facility. The resident was severely agitated and confused. The resident received a platelet transfusion (cell fragments in the blood that forms clots and stop or prevent bleeding) because of the resident's low platelet count in the blood, the brain bleed, and the resident's use of Plavix (antiplatelet drug to prevent blood clots) and Aspirin. A provider prescribed Plavix and Aspirin to the resident because of the resident's coronary artery disease. The resident received comfort cares and passed away eight days after admission to the hospital.

Review of the hospital records indicated during the first hospital visit the resident's platelet count was within normal range. Three days later, the resident's platelet count was low.

During an interview, the primary medical provider stated the resident had increased weakness and was sent to the hospital for an evaluation. The resident received the medications Plavix and Aspirin due to a stent (a tubular support placed temporarily inside a blood vessel, canal, or duct to aid healing or relieve an obstruction) placement. Plavix and Aspirin are medications used to

decrease the chances of a heart attack or stroke. A cardiologist managed the resident's Plavix and Aspirin.

During an interview, leadership stated the resident was able to walk independently until the final week at the facility. The resident's health declined, and the resident had a difficult time walking. The resident was provided an in-house wheelchair, staff were to continue to attempt to have the resident walk, but if it was too unsafe for the resident or staff, the resident was to use the wheelchair. In addition, the resident's primary medical provider requested a physical and occupational therapy referral. Prior to the therapy assessment the resident was admitted to the hospital with a brain bleed and did not return to the facility. The resident was also to be in the common areas when awake. Leadership stated the resident received medications as prescribed by a physician order and medications can only be discontinued with a physician order.

Review of the resident's certificate of death indicated the primary cause of death was complications of a closed head injury from a fall to the floor. Other significant conditions contributing to the cause of death include lung disease, diabetes, coronary artery disease, hypertension, and past prostate cancer.

During an interview, the family member stated the resident walked independently, but in the last week of being at the facility started to decline. The resident walked but became more unsteady. In the last week the facility staff arranged for the resident to use a wheelchair.

During the investigation an additional concern investigated included staff failed to place the resident's back brace on according to provider orders. During an interview, an unlicensed staff member stated the resident wore the back brace when not in bed or as the resident allowed.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented interventions such as, making sure the resident had proper footwear on, a toileting schedule, had the resident in common areas while awake, provided a wheelchair for mobility and was seen at the emergency room on different occasions.

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
	23247	A. BUILDING: _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS PARK COMMONS	1850 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104

(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 On July 27, 2023, the Minnesota Department of Health initiated an investigation of complaint HL232476825M/HL232472836C. No correction orders are issued.	0 000		