Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240283063M
Compliance #: HL240284983C

Date Concluded: July 17, 2023

Name, Address, and County of Licensee Investigated:
Emerald Crest of Victoria
8150 Bavaria Road
Victoria, MN 55386-9702
Carver County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Inconclusive**

Nature of the 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 alleged perpetrator (AP) neglected the resident by leaving the resident alone in the bathroom leading the resident to fall, hit his head, and sustained fractures.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. While the resident was left in the bathroom alone, it is unclear what the care plan instructed at the time of the incident. The facility responded appropriately for the suspected head injury by and sent the resident to the hospital for treatment. The resident received treatment for pain and returned to the facility.

The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living dementia care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, transfers and toileting. The service plan also included the resident needed assisted of one to two person for toileting and transferring. The resident's assessment indicated that the resident was at a high risk of falling.

The facility's internal investigation indicated the resident was left alone in the bathroom and the resident fell. The same document indicated when the resident was found the was sent to the emergency room (ER). The same document included an image of a sign on the resident's door reminding the facility staff members the resident was a high risk for falls and "staff to assist if resident needs to use the bathroom" while not specifically stating to not leave the resident alone in the bathroom. The internal investigation included a screen shot of the resident's care plan which included a note to not leave the resident alone in the bathroom, but it was unclear whether this was added before or after the fall occurred.

The resident's ER records indicated the resident sustained a small abrasion on his head, a nondisplaced right rib fracture and lumbar fracture. The resident was not admitted to the hospital but received a prescription for oral narcotic pain medication and transferred back to the facility.
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The facility's internal investigation indicated the AP, who was an unlicensed caregiver, received education regarding review of the residents' care plans. At the time of the investigation, the facility no longer employed the AP.

During the investigation, despite making multiple attempts, the investigator was unable to reach the alleged perpetrator or other employees who worked the day of the incident.

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: The resident is deceased.
Family/Responsible Party interviewed: Attempts to reach unsuccessful.
Alleged Perpetrator interviewed: Attempts to reach unsuccessful.

Action taken by facility:
The internal investigation was conducted by the facility. The staff member received education and training regarding reviewing and following residents' care plan.

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
	24028	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF VICTORIA	8150 BAVARIA ROAD VICTORIA, MN 55386

(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 June 12, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL240289297C/HL240285403M, #HL240287495C/HL240284424M and #HL240284983C/HL240283063M . No correction orders are issued.	0 000		