Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240285403M
Compliance #: HL240289297C

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: **Not Substantiated**

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 facility neglected a resident when the resident was found lying on the floor for an extended period of time.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined that neglect was not substantiated. However, it should be noted that the resident was found lying on the floor for an unknown period of time and was subsequently sent to the hospital for evaluation. While this incident was an isolated error, the resident did sustain abrasions to their left knee and left shoulder. He received physical therapy and eventually returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. 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 memory care unit. The resident’s diagnoses included Lewy body dementia. The resident’s service plan included assistance of one person with all activities of daily living which included dressing, toileting, and medications. The same document indicated he required supervision and cueing for transfers and mobility.

The resident's care plan indicated the resident had a history of delusions, hallucinations, wandering, and agitation. The same document indicated the resident preferred lying on the floor, and staff members were instructed to encourage and assist the resident in getting onto the bed whenever possible. In case the resident refused, the plan specified the provision of a floor mattress, pillow, and blanket on the floor. The resident received safety checks every 30 minutes but not to be awaken during the night.

According to the resident's progress note, the staff discovered the resident lying face down on the floor in his bedroom with swelling on the left side of his face at about 4 a.m. on the night shift. The staff contacted the on-call nurse, who provided instructions to obtain vital signs, check for any visible injuries, and subsequently called 911. The same documents indicated the facility informed the family and the resident was transported to the hospital.

According to the resident's emergency records, the facility staff reported the resident occasionally chooses to lie on the floor. The same documents indicated the facility staff member(s) found the resident on the floor on his left side with left facial swelling. The resident denied injury or pain and was unsure whether he fell. The duration of time the resident had spent on the floor was unknown. The resident’s blood work included results consistent with an extended period of time lying on the floor.

During an interview, a family member stated the resident had been lying on the floor for over 12 hours. The family received a call from the facility notifying them about the resident's injuries and informing them that they would be sending him to the hospital. The family member further mentioned that according to their understanding, the staff was supposed to check on the resident every hour.

During an interview, an unlicensed caregiver stated the resident preferred sleeping on the floor and caregivers were instructed to offer a pad in the resident's room to provide comfort if he chose to lie on the floor. On the day of the incident, the resident had been on the floor for the entire day, moving from one spot to another. Multiple staff members attempted to assist him in getting up, but he refused. The interviewee, who mostly worked night shifts, recalled offering pillows to make the resident more comfortable, but he pushed the pillows away.

During an interview, a member of the management team stated it was not unusual for the resident to sleep on the floor. On the night of the incident, when the resident wanted to get up,

the staff immediately called for assistance when they discovered the resident's face was red and swollen. Subsequently, they contacted the nurse on call, and based on their assessment, the decision was made to send the resident to the hospital. The director mentioned according to the resident's service plan, reassurance checks were scheduled every 30 minutes throughout the night.

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 had dementia.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility staff diligently adhered to the resident's service plan and promptly called 911 to arrange for the resident to be transported to the hospital.

Action taken by the Minnesota Department of Health:
Insert appropriate action from standard language document

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		