DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259978764M
Compliance #: HL259976245C

Date Concluded: November 22, 2023

Name, Address, and County of Licensee Investigated:
Ecumen Detroit Lakes The Cottage
1435 Madison Avenue
Detroit Lakes, MN 56501
Becker County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, individual 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 it failed to follow the resident's plan of care and toilet the resident when scheduled. The resident fell and broke her femur (thigh bone). The resident was treated in the hospital and admitted to hospice two days later due to ongoing uncontrolled pain. The resident died three days after admission to hospice.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator (AP), an unlicensed personnel (ULP), failed to complete the resident's scheduled toileting and safety check on the overnight shift. The resident was not checked on or toileted for approximately six hours. The resident was found on the floor of her room and was sent to the emergency room where she was diagnosed with a fractured femur. The resident experienced uncontrolled pain and admitted to hospice to help manage the pain. The resident died five days after the fall.

An equal opportunity employer.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included vascular dementia and right leg below the knee amputation. The resident's service plan included assistance with dressing, transfers, toileting, and medication administration. The resident had scheduled toileting times, including at 1:00 a.m. and 5:00 a.m. In addition, the resident had three scheduled safety checks per day, including one at 3:00 a.m. The resident's assessment indicated the resident had impaired short-term memory and needed redirection at all times due to severe disorientation to person, place, or time. The resident was noted to have some difficulty using the call light so needs were to be met per the service plan.

An incident report indicated staff entered the resident's room around 8:00 a.m. and found the resident "on the floor sitting under table holding her knee and crying. Patient had a skin tear on left knee and reported pain in chest and amputated leg. Patient was about 8 feet away from wheelchair, was not wearing shoes but did have socks on." Three people assisted with getting the resident into a chair and 911 was called. Emergency crews arrived approximately 15 minutes later. Facility documentation indicated the resident was last checked on at 1:55 a.m. The resident's 3:00 a.m. toileting and 5:00 a.m. safety checks were not completed.

The facility's internal investigation indicated a miscommunication occurred between the outgoing and oncoming unlicensed personnel (ULP). The ULP coming onto the day shift thought the outgoing night shift ULP/alleged perpetrator (AP) said the resident's safety checks were completed. Thinking the safety checks had been completed, the day shift ULP began assisting other residents for a few hours before returning to the resident's room to help her get up for the day.

Emergency room records indicated the resident was seen in the ER and diagnosed with a femur fracture. Surgical repair was declined due to the resident's "advanced dementia…and the fact that she is generally supposed to be non-weightbearing and using a wheelchair." A closed reduction (a procedure to set a broken bone back in place, allowing it to grow back together) was done and the resident was discharged from the ER back to the assisted living facility with a splint the same day.

Hospice records indicated the resident admitted to hospice two days after the fall to help manage pain as a result of her fracture. The resident died three days after hospice services were initiated.

The resident's death record indicated trauma due to a fall to the floor contributed to the cause of death. The cause of death was listed as complications of hip fracture.

During an interview, the AP stated she was working the night shift on the day the resident fell and was in a lot of pain due to sever back spasms. The AP stated she did not call in sick as the facility used a point system for absences. The AP indicated she was down to her "last point" and she would have been let go if she called in for her shift. The AP stated the other person she was working with left at 2:00 a.m. so the two of them completed rounds before she left and checked

on the resident at that time. The AP stated she was alone until another ULP came in at 5:00 a.m. and at that point "I could barely walk, so I answered lights and just sat so I wouldn't mess up my back more, so from 2:00 a.m. to 5:00 a.m., I answered call lights and waited for the next person to come in and when she did, I let her know that I wasn't able to do rounds in that three hours so I needed help checking people." The AP confirmed she did not complete the 3:00 a.m. safety check and 5:00 a.m. toileting but she assumed the other ULP completed it because she told her they weren't done.

During an interview, the day shift ULP stated she came to work early at 5:00 a.m. the day the resident fell. The ULP stated she wasn't told anything about the resident not being checked on for her scheduled safety check and toileting, so she started her normal routine of answering call lights and getting residents up for the day. The ULP stated the resident normally preferred to get up around 8:00 a.m. so when she entered her room to do morning cares, she discovered the resident on the floor. Another ULP working that day stated he came in to help after the resident was found on the floor. The ULP stated the resident had been bleeding but the blood was dry. Neither ULP knew how long the resident had been on the floor.

During an interview, the registered nurse (RN) stated the while completing the internal investigation, she discovered the 3:00 a.m. safety check and 5:00 a.m. toileting were not completed by the AP. The RN was not sure how long the resident was on the floor when staff entered her room at 8:00 a.m. that morning. The RN stated if a staff member was not able to perform all their expected job duties or had injuries that prevented them from doing their job duties, they were to call the on-call RN or a workability phone line. The RN stated the AP did not call or notify anyone she was unable to perform her duties and did not call any other staff members to come in to help complete her duties.

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: Yes

Action taken by facility:
The facility reported the incident to MAARC. The facility completed a thorough internal investigation and reeducated all staff. The facility revised and reviewed its process for communicating at shift change.

Action taken by the Minnesota Department of Health:
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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Becker County Attorney
Detroit Lakes City Attorney
Detroit Lakes Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25997	A. BUILDING: ______ B. WING ______	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN DETROIT LAKES THE COTTA	**1435 MADISON AVENUE** **DETROIT LAKES, MN 56501**

(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: #HL259978764M/ #HL259976245C On November 6, 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 17 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL259978764M/ #HL259976245C, tag identification 1640, 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
01640 SS=J	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 1 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was implemented per the resident's assessments for one of one residents (R1). The licensee failed to ensure a safety check and scheduled toileting were completed. The resident was not checked on or toileted for approximately six hours and was found on the floor after a fall. The resident suffered a fracture and was admitted to hospice upon her return from the hospital. The resident died five days after the fall. 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	01640		

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01640	Continued From page 2	01640		

affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's diagnoses included vascular dementia and right below the knee amputation.

R1's service plan dated July 24, 2023, indicated the resident received assistance with dressing, transfers, toileting, and medication administration. The resident had scheduled toileting throughout the day, including at 1:00 a.m. and 5:00 a.m. In addition, the resident had scheduled safety checks, including one at 3:00 a.m.

The resident's assessment dated September 26, 2023, indicated the resident had impaired short term memory and needed redirection at all times due to severe disorientation to person, place, or time.

An incident report completed on September 24, 2023, indicated staff entered the resident's room around 8:00 a.m. and found the resident "on the floor sitting under table holding her knee and crying. Patient had a skin tear on left knee and reported pain in chest and amputated leg. Patient was about 8 feet away from wheelchair, was not wearing shoes but did have socks on." Three people assisted with getting the resident into a chair and 911 was called. Emergency crews arrived approximately 15 minutes later. Facility documentation indicated the resident was last checked on at 1:55 a.m. The resident's 3:00 a.m. toileting and 5:00 a.m. safety checks were not completed.

The facility's internal investigation indicated a

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miscommunication occurred between the outgoing and oncoming unlicensed personnel (ULP). The ULP coming onto the day shift thought the outgoing night shift ULP said the resident's safety checks had been completed, when they actually had not been. Thinking the safety check had been completed, the day shift ULP began helping other residents for a few hours before returning to the resident's room to help her get up for the day.

Emergency room records indicated the resident was seen in the ER on September 24, 2023, and diagnosed with a femur fracture. Surgical repair was declined due to the resident's "advanced dementia ...and the fact that she is generally supposed to be non-weight bearing and using a wheelchair." A closed reduction (a procedure to set a broken bone back in place, allowing it to grow back together) was done and the resident was discharged from the ER back to the assisted living facility with a splint the same day.

Hospice records indicated the resident admitted on September 26, 2023, to help manage pain as a result of the resident's fracture. The resident died on September 29, 2023.

The resident's death record indicated trauma due to a fall to the floor contributed to the cause of death. The cause of death was listed as complications of hip fracture.

On November 6, 2023, at 11:50 a.m., registered nurse (RN)-A stated during their internal investigation, she discovered the 3:00 a.m. safety check and 5:00 a.m. toileting had not been completed. RN-A stated she was not sure how long R1 had been on the floor when staff entered her room at 8:00 a.m. that morning. RN-A stated

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the resident returned from the hospital on bed rest and the resident was admitted to hospice shortly after her return due to uncontrollable pain.

On November 7, 2023, at 9:50 a.m., ULP-B stated she had been working the overnight shift the day R1 had her fall and completed her shift at 6:30 a.m. ULP-B stated she had been having severe back spasms and was in a lot of pain but did not call in as the facility used a point system for absences and she was down to her last point and she'd be let go if she called in for her shift. ULP-B stated the other person she was working with left at 2:00 a.m. so the two of them did rounds before she left. ULP-B stated she was alone until another ULP came in at 5:00 a.m. and at that point "I could barely walk so I answered lights and just sat so I wouldn't mess up my back more so from 2:00 a.m. to 5:00 a.m., I answered call lights and waited for the next person to come in and when she did, I let her know that I wasn't able to do rounds in that three hours so I needed help checking people." ULP-B confirmed she did not complete the 3:00 a.m. safety check and 5:00 a.m. toileting but she assumed the other ULP completed it because she told her they weren't done.

On November 7, 2023, at 4:25 p.m., ULP-D stated she came to work early at 5:00 a.m. on September 24, 2023. ULP-D stated she wasn't told anything about R1 not being checked on for her scheduled safety check and toileting so she started her normal routine of answering call lights and getting residents up for the day. ULP-D stated R1 normally preferred to get up around 8:00 a.m. so when she entered her room to do morning cares, she discovered the resident on the floor.

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01640	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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 residents 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.	