Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273983082M
Compliance #: HL273985052C

Date Concluded: September 12, 2023

Name, Address, and County of Licensee Investigated:
Ecumen Seasons at Maplewood
1670 Legacy Parkway East
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Lori Pokela, R.N.
Special Investigator

Finding: Substantiated, facility responsibility

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 the resident when the resident sustained six falls within 2 weeks. The resident was not assessed following each fall, not monitored for injury, and no interventions were implemented to prevent further falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Staff failed to follow facility policies and procedures related to falls. Although the resident had a history and identified risk for falls, nursing staff failed to assess, treat, and monitor, the resident after falls with injury occurred. In addition, no new interventions were created to prevent further falls.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospice staff. The investigation included review of the resident's medical records, hospital records, hospice

records, and death records. At the time of the onsite visit, the investigator observed medication and treatment administration and resident cares provided by facility staff.

The resident resided in an assisted living facility memory care unit and received hospice services. The resident's diagnoses included Alzheimer's Disease, Osteoarthritis (a disease that causes the cartilage between the bones to wear down and rub together) and Osteopenia (a disease that causes the bones to be brittle). The resident's service plan indicated the resident was cognitively impaired and directed staff to anticipate needs, provide cues, reminders, and redirection as needed. The resident required 1-2 staff for assistance with transfers and utilized a Broda Chair (a wheelchair with four wheels that reclines and is used for proper positioning) for mobility. The resident was at high risk for falls, wore a motion detector to alert staff to immediately respond during night hours, had a floor mat next to the bed, and physician orders for scheduled and as-needed (PRN) medication for pain relief and behavior management.

Review of facility documentation and the resident's medical record identified the resident fell six times over a two-week period.

The first fall report indicated the resident was found sitting on the floor in her bedroom. The report identified the resident sustained two skin tears to her right arm. There was no documentation available to support the skin tear was monitored, when/if it resolved, and no additional fall interventions were implemented to prevent further falls.

The second fall occurred two days later. The fall report indicated the resident fell in her bathroom and was found lying on her back on the floor. No additional fall interventions were implemented to prevent further falls.

The third fall occurred the next day. The fall report indicated the resident was found lying on her back next to her bed. The fall report did not identify if any injury was sustained, and no additional fall interventions were implemented to prevent further falls. The resident's family took a photo of the resident's left wrist on the day of the fall. The resident's wrist appeared swollen in the photo. According to the resident's medical records, the resident was seen by the physician the following day, however, there was no paperwork or documentation available related to the visit.

The fourth fall occurred nine days later. The fall report indicated the resident was found in her bedroom, laying on her side, with her head under the bed frame. The fall report indicated the resident had "no new bumps and bruising" from the fall. No additional fall interventions were implemented to prevent further falls.

The fifth fall occurred the next day. The resident was found on the floor in her room near her Broda chair. Facility staff and the hospice nurse observed the resident to be restless, yelling out, fidgeting, and attempting to get out of her Broda chair unassisted. The resident's medical records indicated the resident's behavior medications were adjusted at that time, but the

medication adjustment was ineffective. The fall report indicated the resident sustained “some bruises and a bump above her left eyebrow area.” Facility, triage, and hospice nursing staff directed unlicensed staff to administer as needed (PRN) behavior medications and apply an ice pack to the resident’s left eyebrow. The resident’s medical records lacked documentation of the left eyebrow injury and there was no evidence of monitoring of the area or indication the injury resolved. No additional fall interventions were implemented to prevent further falls.

Two days later, the resident fell for the sixth time and fractured her left hip. The fall report indicated the resident was found on the floor in her bedroom. New interventions included a review of medications and changes in pain and behavior medications.

The facility was not able to provide information regarding the motion detector placed in the resident’s room for all six falls.

During an interview, facility staff and hospice nursing staff indicated the facility was responsible for documentation of any post-fall follow up and additional fall prevention interventions, not hospice staff.

During an interview, the resident’s family member stated the resident was supposed to be placed in a community area so staff could monitor the resident’s safety. The resident’s family member felt that when the resident’s motion detector alarmed, staff took a long time to check on the resident.

During an interview, facility and organizational staff, hospice staff, and the resident’s case manager, stated fall interventions were put in place by the facility as they were the primary caregivers. The resident’s hospice nurse case manager stated that hospice personnel could make intervention recommendations, but facility nursing staff were responsible for placing and implementing the information on the resident’s plan of care.

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: Not Applicable (N/A)

Action taken by facility:
None.

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
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27398	A. BUILDING: _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

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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: #HL273985052C/# HL273983082M #HL273982187C On June 1, 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 61 residents receiving services under the provider's Assisted Living/Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL273985052C/#H273983082M , tag identification: 2310.	0 000		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 1 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of nine residents (R1) reviewed for falls. The licensee failed to ensure injuries were monitored and/or resolved and failed to develop and implement new interventions related to the root cause of the falls. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are 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, but were not limited to, Alzheimer's disease, Osteoarthritis and Osteopenia. R1's service plan dated July 29, 2021, indicated the resident required staff assistance with activities of daily living (ADL's), had cognitive impairments, needed staff assistance with safety checks, to be wearing a call pendent at all times, staff reminders to use the walker and was in high fall risk.	02310		

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02310	Continued From page 2 R1's progress notes dated October 23, 2021, indicated the resident utilized a motion sensor on her bed. Documentation that a motion sensor was being monitored was not provided. R1's progress notes, dated January 18, 2022, at 11:30 a.m., indicated R1 had a change in condition and would be using a Broda Char for all mobility. R1's 90-day assessment, dated July 28, 2022, indicated the resident was receiving the licensee's organizational hospice services services, had multiple falls within two weeks of the assessment being completed, needed staff assistance of one person for all transfers, used a Broda Chair for mobility and a floor mat by the bed. The assessment also indicated R1 was on a behavior management plan and safety checks, every two hours and up to twelve times per day. The assessment further indicated R1 recieved staff assistance with medication administration which included medication for pain and behaviors. R1 Falls: Fall 1: An incident report dated July 25, 2022, at 5:30 a.m., indicated R1 obtained two skin tears from an unwitnessed fall after self-transferring. The root cause analysis (RCA) included: history of falls, vision/hearing deficits, impaired safety judgement and weakness. Current Interventions: R1's hospice case management to visit and evaluate R1, staff will assist with transfers and ADLs, locomotion and assistive devices. The incident report lacked content regarding any new fall prevention intervention(s) were provided.	02310		

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02310	Continued From page 3 R1's progress notes dated July 25, 2022, at 6:48 a.m., signed by R1's hospice triage registered nurse (RN)-P, to instruct facility staff to monitor R1 for changes or concerns after the fall and call back for questions or any changes regarding R1's fall. R1's progress notes dated July 25, 2022, at 5:22 p.m., signed by licensed practical nurse (LPN)-E, indicated R1's hospice orders for treatment to right forearm skin tear to be completed twice per week. No documentation was provided regarding R1's hospice order for skin tear monitoring, treatment or resolve date, in R1's medication administration records (MAR) , treatment administration records (TAR) or other medical records documents. Fall 2: An incident report dated July 27, 2022, at 3:30 a.m., indicated R1 was found agitated on the floor in her bathroom. The incident report indicated R1 did not sustain injuries. The incident report lacked content of a root cause analysis (RCA) or that any new fall prevention intervention(s) were provided. Fall 3: An incident report dated July 28, 2022, at 11:50 a.m., indicated R1 was found on the floor without injury in her bedroom, lying on her back. The root cause analysis (RCA) included: history of falls, vision/hearing deficits, impaired safety judgement and was resistive to cares. Interventions included: R1's service plan and nursing assessment were updated. Other current	02310		

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02310	Continued From page 4 interventions documented included: equipment would be checked for wear and tear, staffing patterns were reviewed and care would be coordinated with the hospice services. The incident report lacked content regarding any new fall prevention intervention(s) were provided. R1's progress notes dated July 28, 2022, at 9:35 a.m., signed by LPN-E, indicated the nurse would call R1's hospice service to discuss frequent unwitnessed falls and inquire regarding R1's safety. R1's medical records lacked content that a follow-up discussion was conducted with R1's hospice personnel. R1's progress notes dated July 29, 2022, at 3:52 p.m., included late entry documentation signed by RN-P regarding R1's fall on 7/28/22 , instructed facility staff to monitor R1 for changes or concerns after the fall and call back for questions or any changes. R1's progress notes dated July 29, 2022, at 2:04 p.m., signed by LPN-E , indicated R1 had a physician visit with no new orders. R1's progress notes dated July 31, 2022 at 8:38 a.m. and 8:39 a.m. signed by unlicensed personnel, (ULP)-R, indicated R1's medication for restlessness had been changed. Fall 4: An incident report dated August 6, 2022, at 4:05 a.m., indicated R1 was found on the floor, lying on her side, with her head under the bed. The incident report lacked content of a root cause analysis (RCA) or that any new fall prevention intervention(s) were provided.	02310		

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02310	Continued From page 5 R1's progress notes dated August 6, 2022, at 4:14 a.m., signed by RN-P, instructed facility staff to monitor R1 for changes or concerns after the fall and call back for questions or any changes after R1's fall. No further information was provided. Fall 5: An incident report dated August 7, 2022, at 7:15 p.m., indicated R1 had been in the Broda Chair when the fall had occurred. The incident report indicated R1 obtained bruises and a bump above her left eyebrow. The RCA included: R1 had impaired cognition, confusion and agitation. Interventions included: continue to adjust medications, looking at quiet versus busy environments, staff education and use Broda Chair at night. The incident report lacked content regarding any new fall prevention intervention(s) were provided. The resident's medical records lacked content that indicated a quiet versus busy environment had been discussed. R1's progress notes dated August 7, 2022, at 7:31 p.m., signed by R1's hospice triage registered nurse (RN)-Q, indicated hospice staff instructed facility staff to administer an as needed (PRN) medication and place an ice pack to R1's left eyebrow, monitor R1 and update hospice as needed regarding R1's fall. There was no documentation of R1's hospice order for left eyebrow monitoring, treatment, or resolved date, in R1's MAR, TAR ,or other medical records. R1's progress notes dated August 8, 2022, at 1:24 p.m., signed by LPN-E indicated R1's behavior medication orders were changed.	02310		

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02310	Continued From page 6 R1's progress notes dated August 8, 2022, at 4:03 p.m., by R1's former hospice registered nurse case manager (RN)-G, indicated R1's hospice nurse visited and observed R1 yelling out, fidgeting, and attempting to get out of her chair. The progress note indicated the resident's family had concerns regarding R1's behavior medication and the hospice nurse changed R1's behavior medications. The progress note also indicated the hospice nurse instructed staff to continue to monitor R1 for agitation, restlessness, falls, and continue comfort focus cares. Fall 6: An incident report dated August 10, 2022, at 1:00 a.m., indicated R1 was found on the floor of her bedroom, and obtained a left hip fracture. The RCA included: history of falls, vision/hearing deficits, impaired safety judgement, impaired mental status, gait disorder and weakness. Interventions: Service plan updated, documentation in nurse progress notes, medication review. Current interventions listed included: the use of Broda Chair added, staffing patterns reviewed, staff education, safe care plan in place and resident receiving hospice services. The incident report lacked content regarding any new fall prevention intervention(s) were provided. An updated service plan was not provided. R1's progress notes dated August 10, 2022, at 12:56 a.m., signed by RN-P, indicated R1 was found on the floor next to her bed, R1 had complaints of leg pain and had no injuries. RN-P instructed staff to get R1 off of the floor with two staff check vital signs then call back to update. R1's progress notes dated August 10, 2022, at	02310		

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02310	Continued From page 7 1:10 p.m., signed by RN-P, indicated unlicensed personnel, (ULP)- H, called RN-P back and asked if R1 could get up off of the floor with a mechanical lift and stated R1 was agitated and yelling about pain in her left leg. ULP-H was not able to get vital signs due to R1's to agitation. This same document indicated RN-P could hear R1 yelling: "ow, ow and ahhh" and instructed ULP-G to give R1's PRN pain and behavior medications. This same document also indicated RN-P instructed ULP-H to call back in one hour if no relief or decrease in symptoms, to monitor for changes, concerns and call back twenty-four hours per day for questions or changes. R1's progress notes dated August 10, 2022, at 2:20 p.m. signed by RN-P, indicated R1's family member was with R1 and had requested an immediate visit from R1's hospice nurse due to severe pain in R1's left leg. The progress notes indicated RN-P called RN-G to request to visit R1, RN-G would be at the facility in an hour. R1's progress notes dated August 10, 2022, at 3:54 a.m. signed by RN-P indicated RN-G had R1's new medication orders for post-fall pain and behaviors entered with no other changes. R1's hospice progress notes dated August 10, 2022, at 10:36 a.m., signed by R1's hospice registered nurse, (RN)-S, indicated R1 was having pain and had bruising to her left eye in various stages of healing. The progress notes indicated R1 had an x-ray completed on her left hip and RN-S instructed staff R1 was to be placed on bedrest, to be turned and repositioned every two hours. There was no documentation on R1's MAR, TAR or other medical records was provided regarding	02310		

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02310	Continued From page 8 monitoring, treatment or resolved dates of R1's left eye bruises. R1's progress notes dated August 10, 2022, at 11:15 a.m., signed by RN-G, indicated R1 to continue to be restless, agitated and yelling "ow." The progress notes indicated RN-G was not able to obtain vital signs and RN-G could barely touch R1's left leg. The progress notes indicated staff to continue to monitor pain, restlessness and agitation. On July 14, 2023, at 10:33 a.m., R1's family member (FM)-N provided a photo that indicated R1 had a bruise encircled around her left eye. The photo had a handwritten date and note of: (August 10, 2022, the afternoon of the fall.) During an interview, dated July 7, 2023, at 1:35 p.m., RN-G stated: "The facility works towards fall prevention intervention." During an interview, dated July 12, 2023, at 2:59pm, FM-N stated R1 had a camera installed in R1's room. FM-N confirmed R1 had multiple falls and stated licensee staff would place her in the "Great Room" with the Broda Chair reclined back to be able to better monitor her but stated that staff were not always able to monitor. FM-N confirmed R1 had used a motion detection device while in her room, but FM-N stated staff ignored when the alarm went off. During an interview, dated July 26, 2023, at 1:33 p.m., RN-K stated in regard to a resident's equipment, safety, wear and tear: "Staff typically looked at resident's equipment for those items on the resident's shower day."	02310		

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02310	Continued From page 9 During an interview, dated July 31, 2023, at 9:33 a.m., hospice registered nurse (RN)-L stated the licensee was responsible for the development of post-fall prevention interventions due to the licensee providing the primary care to the resident. RN-L also stated the organization's hospice does recommend post-fall prevention interventions in collaboration with the licensee, however, it is the licensee's responsibility to update the interventions on the resident's plan of care. The undated Hospice Care for Nursing Facility Residents-Hospice Plan of Care policy indicated a written plan of care is established and maintained for each hospice resident who resides in a licensee and is developed and coordinated with hospice, the resident's physician and licensee personnel. (1) The hospice registered nurse assigned to the licensee is responsible for coordinating and implementing the resident's plan of care in collaboration with representatives from the licensee. The licensee's Falls and Fall Risk Managing Policy dated March 2018 included: (1) The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The licensee's undated Monitoring Subsequent Falls and Fall Risk: (3) If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.	02310		

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02310	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		