Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL277972885M
Compliance #: HL277974815C

Date Concluded: June 2, 2023

Name, Address, and County of Licensee Investigated:
PHC Laramie
1817 Laramie Trail
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, 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 and alleged perpetrator (AP)-1, AP-2, and AP-3 neglected a resident when they failed to call emergency medical service for 12 hours despite knowing the resident was unconscious during that time.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. AP-1, AP-2, and AP-3 continually assessed the resident and reported changes in the resident's status to the provider and administration. AP-1 called emergency medical services when the resident's condition worsened.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted law enforcement, the hospital case worker, and paramedic. The investigation included review of the resident's medical record, employee files,

incident reports, and facility policies. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included encephalopathy, respiratory failure with tracheostomy, gastrostomy, diabetes, and seizure disorder. The resident's service plan included assistance with medication, tube feedings, monitor ventilator, grooming, bathing, and repositioning. The resident's assessment indicated the resident was not oriented to person, place, or time. The resident was not able to follow simple commands consistently and was non-verbal.

During an interview, a paramedic stated the staff told her the resident was unresponsive for 12 hours. The paramedic stated the resident was not tracking with his eyes and he was pale and sweaty. The paramedic stated the facility staff stated he was not his normal self for about 12 hours. The paramedic stated the resident was in septic shock and his vitals were unstable. The paramedic stated sometimes people transition from sepsis to septic shock quickly but other times it can take days.

During an interview, AP-1, who is also a nurse, stated the resident was responsive during her shift. AP-1 stated the resident is non-verbal but does open his eyes. AP-1 said the resident's temperature and pulse increased in the middle of her shift and she administered Tylenol (anti-fever medication) and AP-2 completed a bed bath with the resident. AP-1 stated she contacted the nurse on-call and sent the resident to the hospital when his temperature and pulse worsened.

During an interview, AP-2, who is also a nurse, stated she was working with AP-1 during the incident, but was assigned to different residents. AP-2 stated AP-1 asked her to assess the resident together. AP-2 stated she assessed the resident and gave the resident a bed bath. AP-2 stated the resident had a low-grade fever and an increased pulse. AP-2 stated the resident was responsive during her shift and opened his eyes. AP-2 stated AP-1 called the on-call registered nurse and sent the resident to the hospital after the resident's temperature and pulse increased. AP-2 stated she would call emergency medical services immediately if a resident was unresponsive. AP-2 stated emergency medical services must have been confused the report given to them as the resident is non-verbal but was not unresponsive or unconscious.

During an interview, AP-3, who is also a nurse, stated she worked the day shift with the resident. AP-3 stated the resident had a low-grade fever, a slightly elevated pulse, and a larger amount of residual (fluid not absorbed yet from stomach) than usual. AP-3 stated she informed the resident's provider of the findings. The resident's provider ordered an x-ray and labs. AP-3 stated the resident was responsive during her shift and the information was reported to the next shift to continue to monitor and await lab results. AP-3 stated they were aware of the resident's change in condition and completed the appropriate process for care.

According to a text message sent from AP-1's cell phone to the on-call registered nurse mid shift, AP-1 reported the resident's temperature had increased despite interventions. AP-1 reported the resident's pulse had also increased and they were planning to send the resident to the hospital. The text message also indicated the resident's provider suspected the resident had a urinary tract infection and lab results were pending.

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, deceased.
Family/Responsible Party interviewed: No, would not have relevant information to add.
Alleged Perpetrator interviewed: Yes, AP-1, AP-2, and AP-3.

Action taken by facility:
The nurses monitored the resident continuously and reported changes in condition.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27797	A. BUILDING: _____ B. WING _____	C 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHC LARAMIE	1817 LARAMIE TRAIL BROOKLYN PARK, MN 55444

(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: #HL277974815C/#HL277972885M On May 25, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL277974815C/#HL277972885M, tag identification 1400.	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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	
01400 SS=D	144G.62 Subdivision 1 Availability of contact person to staff	01400		

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01400	Continued From page 1 (b) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff could access the registered nurse (RN) at any time due to the RN on-call failing to respond to a medical emergency concern for an extended period for one of one residents (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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 admitted August 9, 2022. His diagnoses included anoxic encephalopathy, respiratory failure with chronic tracheostomy ventilator dependent, gastrostomy, seizures, diabetes, and septic shock. R1 was unable to communicate verbally. R1's progress note dated August 31, 2023, indicated R1 had an elevated temperature and pulse. R1 had an increased amount of residual fluid. R1's provider ordered several labs and tests. R1's condition continued to worsen through the night. R1's pule remained elevated and R1's temperature continued to increase despite fever	01400		

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01400	Continued From page 2 reducing medication. On September 1, 2022, at 2:34 a.m., licensed practical nurse (LPN)-A sent a text message to assistant director of nursing (ADON)-D with an update on a resident's medical status. The message from LPN-A requested guidance on the situation. On September 1, 2022, at 4:05 a.m., ADON-D responded via a text message to LPN-A's question. During an interview on June 1, 2023, at 12:05 p.m., LPN-A stated ADON-D responded via text to her concerns at 4:05 a.m. During an interview on June 2, 2023, at 3:28 p.m., chief nursing officer (CNO)-F stated the on-call nurse has one hour to respond to a staff member's call; CNO-F said this was per the licensee's policy. The licensee's Availability of an RN for Staff policy dated January 1, 2021, indicated the on-call registered nurse must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. TIME PERIOD FOR CORRECTION: Seven (7) DAYS	01400		