Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294563443M
Compliance #: HL294565556C

Date Concluded: July 12, 2023

Name, Address, and County of Licensee Investigated:
Keystone Bluffs
2528 Trinity Road
Duluth, MN 55811
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, 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):
Facility staff neglected the resident when they failed to provide the resident with appropriate care and services including toileting assistance to prevent incontinence, bathing, and changing clothes. In addition, facility staff failed to provide the resident with supervision to prevent falls. The resident died approximately nine hours after a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided for the resident's assessed, and care planned needs as the resident allowed. The resident received hospice end of life care with additional supportive services provided to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of the resident's medical record, service delivery record, hospice records, incident reports, call light report, staff schedules, and facility policies and procedures. Also, the investigator observed staff assisting residents.

The resident resided in an assisted living facility. The resident's diagnoses included lung cancer, bladder cancer, prostate cancer, and chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with walking, toileting, dressing, grooming, bathing, and medication management. The resident used a walker for transfers and walking, required continuous oxygen, and experienced shortness of breath at rest causing anxiety and impulsivity. The resident's assessment indicated the resident was alert and able to make needs known, and at high risk for falls.

The facility progress notes indicated during the eight weeks at the facility, the resident experienced increased urinary urgency, difficulty urinating, and extra body fluid with increased shortness of breath that required medications to decrease the fluid.

Review of the contracted hospice notes indicated the resident admitted to hospice services for end-of-life care approximately one week following admission to the facility. The hospice plan of care indicated the hospice aide visited the resident initially two times a week to provide the resident assistance with bathing, dressing, grooming, and toileting assistance. The hospice services increased over the following eight weeks due to the resident's decline in abilities. The resident experienced increased falls and the facility along with hospice staff, and family arranged for increased staffing and supervision of the resident. Despite the increased supervision, the resident continued to fall due to weakness, shortness of breath, and attempts at self-transferring.

The hospice notes indicated about three weeks after admission to hospice, a urinary catheter was placed due to the addition of a diuretic (increased passing of urine) medication for fluid retention, however, less than a day later, the resident pulled out the catheter causing blood clots. There was no evidence to indicate staff failed to assist the resident with toileting causing incontinence.

Additional fall preventions interventions added included a low bed with a mat next to the bed, every 15-minute safety checks, reminders to use the call pendant to summon staff, moved the resident's room closer to the nurse station, arranged the resident's bed against one wall, kept the door to the resident's room open for observations, and one to one supervision when available through an agency and arranged by the family.

Review of the facilities call light report indicated prior to the last fall, staff responded to the resident call pendant about one-half hour prior to the fall. The report indicated the resident did not use the call pendant to summon for staff assistance prior to the fall.

During an interview, an unlicensed professional (ULP) stated the resident could use the call light but often transferred himself without calling for staff assistance.

During an interview, a registered nurse (RN) stated the resident was impulsive and would not wait for assistance from staff. The RN stated the resident was alert and oriented with poor short-term memory. The RN stated for the resident's safety, hospice staff provided additional staff for the resident, facility staff placed the resident on frequent safety checks, and the family had an outside person sit with the resident when available. The RN stated the day the resident fell, another resident found him on the floor and alerted staff. After the fall, the resident was brought to the nurse's station for observation and hospice was notified of the fall. While at the nurse's station, the resident had a seizure, was brought back to his room after the seizure and was placed in bed. Hospice arrived and began seizure medications. The resident passed away later that day.

The resident's death record indicated the resident's cause of death was lung cancer. Additional significant conditions contributing to the resident's death included bladder cancer, prostate cancer, and severe chronic obstructive pulmonary disease.

During an interview, a family member stated the resident was able to walk and used a walker for assistance. The family member stated a sitter was hired to sit with the resident for five to six hours three times a week.

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 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
After the resident fell, the resident was brought to the nurse’s station for continuous monitoring, hospice and the family were notified.

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
	29456	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE BLUFFS	2528 TRINITY ROAD DULUTH, MN 55811

(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 complaint #HL294565556C/#HL294563443M. No correction orders are issued.	0 000		