Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294568465M
Compliance #: HL294565686C

Date Concluded: January 22, 2024

Name, Address, and County of Licensee Investigated:
Keystone Bluffs Assisted Living
2528 Trinity Road 301
Duluth, MN 55811
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility 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 a resident when they failed to provide care, services, and supervision to prevent falls. The resident had several falls in two days and sustained a distal femur fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had several falls over a two-day period and complained of pain and staff noted swelling in the resident right knee. The resident was not provided care and services according to the resident's specific needs including toileting, incontinence care, and supervision at the time of the falls. An X-ray was obtained four days after the resident's last fall. The resident was diagnosed with a distal femur fracture and admitted to the hospital for pain management.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the residents medical

and hospital record, hospice documentation, facility incident reports, and facility policies and procedures. Also, the investigator observed resident's and staff in the facility.

The resident resided in an assisted living facility with diagnoses including dysphasia (impairment in the ability to speak due to brain disease or damage), late onset Alzheimer's Disease, dementia, and anxiety.

The resident's service plan indicated the resident received assistance with medication administration, and safety checks 11 times daily.

The resident's admission assessment indicated the resident had no known falls in the six months prior to admission. The assessment indicated the resident had cognitive impairment and was unable to use a call light or ask for assistance. The resident received hospice end of life care, and was dependent on staff for dressing, grooming, and required extensive assistance using a sit to stand mechanical lift for transfers, toileting, and incontinence cares every two to three hours.

The resident's care plan indicated the resident was unable to communicate her needs and did not have a call light to ring for assistance. The resident was incontinent, and staff were to assist the resident with incontinence care every "two to three hours."

The resident's hospice assessment and care plan during the time of the resident's falls indicated the resident was mostly nonverbal, and required staff assistance with mobility, and incontinence care.

An admission progress note indicated the resident was incontinent and instructed staff to check, change, and toilet the resident every two to three hours. The note indicated the resident had difficulty making her needs known and did not use a call light.

A facility incident report indicated staff found the resident on the floor next to her bed with a 1 centimeter (cm) by 5 cm abrasion to the outside of her left knee. The report indicated the resident was incontinent of urine at the time of the incident, however, the resident was unable to communicate her needs to staff. The report indicated interventions to prevent further falls included reminding the resident to use her call light.

The second incident report indicated six hours later the resident had another fall after sliding out of the wheelchair. The incident report indicated hospice would provide a floor mat.

The resident record contained no documentation regarding implementation of a floor mat as a fall intervention.

A hospice post incident nurses note indicated when the nurse assessed the resident and attempted range of motion the resident began to cry, indicating the resident had significant

pain. The resident's right knee was swollen, and the resident cried and retracted her leg when the nurse attempted to place her foot on the pedal of her wheelchair. The nurse notified the resident's provider and an Xray was ordered to assess the resident for injuries.

The following day, a facility incident report indicated the resident was again found lying on the floor next to her bed. The resident complained of knee pain and winced with attempts at range of motion. The incident report indicated the resident was trying to get out of bed, possibly to use the bathroom. The fall interventions that would be implemented included reminding the resident to use her call light.

Three days later, a follow-up progress note indicated the resident's family member reported the resident had increased pain in her right leg and knee since the fall. The note indicated the resident's right knee was considerably larger than the left knee, and the resident winced with pain when it was extended slightly.

When interviewed staff who responded to the resident after her third fall indicated the resident had no fall mat in place to prevent injury, and the resident was reminded to use her call light.

A radiology report indicated the residents Xray was obtained four days after the provider orders were placed for evaluation of the resident's pain and swelling. The radiology report indicated the resident had suspicious findings of an acute significantly displaced fracture of her right distal femur.

The residents record indicated the resident was admitted to the hospital the following day for a distal femur fracture and pain control, then returned to the facility one week later.

The resident's scheduled services included safety [courtesy] checks 11 times daily, scheduled approximately every two hours. The service report indicated the day of the first incident, the resident was scheduled to have a safety check at 2:00 a.m. however, there is no documentation staff checked on the resident. The resident was found on the floor 30 minutes later.
No safety checks were provided as scheduled to the resident after the fall occurred, then the second fall incident occurred six hours later. The following day the resident received no safety checks as scheduled from 8:00 a.m. till 10:00 p.m., and the resident was found on the floor at 10:30 p.m. The services report failed to direct staff regarding the resident's scheduled toileting or incontinence care every two to three hours as indicated in the resident's care plan when the falls occurred.

When interviewed, licensed and unlicensed staff stated safety checks [courtesy visit] were to check on the resident and ensure the resident is safe. The staff stated if a resident received toileting and incontinence care it would be a separate scheduled service aside from just a safety check. Staff stated after the resident fell, she had significant pain, swelling, and changes in mobility for several days before the resident was diagnosed with a femur fracture.

When interviewed nursing staff stated they did not know why there was a delay in obtaining the ordered Xray, and indicated leadership nursing staff were responsible to make sure things were done timely.

When interviewed leadership staff stated the resident had no pain or signs of injury until several days following the last fall, which is when they obtained the Xray which identified the femur fracture. The leadership staff stated the resident required staff assistance with toileting and incontinence care every two to three hours, which should have been listed on the resident's services. Leadership staff stated every two-hour repositioning, and incontinence cares were not added to the resident's services until after the resident was readmitted from the hospital. The leadership staff stated the residents' services are what staff follow to determine a resident's individualized plan of care.

The resident record of death indicated the resident died of natural causes related to Alzheimer's Dementia, with contributing factors including a closed right femur fracture.

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: N/A

Action taken by facility:
When the resident was readmitted to the facility from the hospital, services including every two-hour repositioning and incontinence care were implemented.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

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 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE BLUFFS ASSISTED LIVING	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 ******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: #HL294565686C//#HL294568465M On December 12, 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 86 residents receiving services under the provider's Comprehensive Assisted Living license. The following correction orders are issued for #HL294565686C//#HL294568465M, tag identification 2310, and 2360.	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 resident's needs and according to an up-to-date	02310		

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02310	Continued From page 1 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide appropriate care, services, and supervision for one of one residents (R1) with recurring falls. The resident record lacked documentation of appropriate interventions implemented to help prevent recurring falls and injury. The resident had several falls in two days. The licensee failed to ensure an X-ray was obtained timely as ordered to assess the resident's pain and swelling after the falls occurred. The resident was harmed when R1 sustained a distal femur fracture and was admitted to the hospital for fracture management and pain control five days after R1's last fall. . 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). Findings include: R1 was admitted to the facility on August 21, 2023, with diagnoses including dysphasia (impairment in the ability to speak due to brain disease or damage), late onset Alzheimer's Disease, dementia, and anxiety. R1's service plan dated September 18, 2023,	02310		

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02310	Continued From page 2 indicated R1 received assistance with medication administration, and courtesy visits (safety checks) 11 times daily. R1's admission assessment dated August 28, 2023, indicated R1 had no known falls in the last six months prior to admission. The assessment indicated R1 was cognitively impaired and unable to use her call light or ask for assistance. R1 was dependent on staff for activities of daily living including dressing, grooming, toileting, and incontinence cares every two to three hours. R1 required extensive assistance with mobility using a sit to stand mechanical lift for transfers and received hospice end of life care. R1's care plan indicated due to cognitive impairment R1 was unable to communicate her needs and did not have a call light to ring for assistance. The care plan indicated R1 required two staff and a mechanical sit to stand lift for transfers, was incontinent, and staff were to assure cleanliness by providing incontinence care as scheduled every two to three hours. R1's hospice assessment and care plan (during the time of R1's falls) from August 16, 2023, to September 9, 2023, indicated R1 was mostly nonverbal, and required staff assistance with mobility, and incontinence care. On August 24, 2023, at 2:59 p.m. a progress note indicated R1 was incontinent and instructed staff to check, change, and toilet R1 every two to three hours. The note indicated R1 had aphasia, difficulty making her needs known, and did not use a call light. On September 1, 2023, at 2:30 a.m. an incident report indicated staff found the resident on the	02310		

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02310	Continued From page 3 floor next to her bed with a 1 centimeter (cm) by 5 cm abrasion to the outside of her left knee. The report identified the resident was incontinent of urine at the time of the incident but could not communicate her needs to staff. The report indicated interventions implemented at the time of the fall included reminding the resident to use her call light. On September 1, 2023, at 8:30 a.m. six hours later, a second incident report indicated R1 had another fall when she slid out of her wheelchair. The incident report indicated hospice was to provide a floor mat, however there was no indication a fall mat was implemented on R1's care plan. On September 1, 2023, at 11:35 a.m. an outside medical record post incident hospice nurses note indicated when the nurse assessed R1 and attempted range of motion R1 began to cry, indicating she had significant pain. R1's right knee was swollen, and R1 cried and retracted her leg when the nurse attempted to place R1's foot on the pedal of her wheelchair. The nurse notified R1's provider and an X-ray was ordered to assess R1 for injuries. On September 1, 2023, a provider faxed communication titled "Fall Tracker" indicated it was reported to the provider R1 had pain and swelling in R1's right knee after a fall, with orders received to obtain an X-ray. On September 2, 2023, at 10:25 p.m. another incident report indicated R1 was again found lying on the floor next to her bed. The incident report indicated R1 complained of knee pain and winced with attempt at range of motion. The incident report indicated R1 was trying to get out of bed,	02310		

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02310	Continued From page 4 possibly to use the bathroom. The report indicated interventions implemented at the time of the fall included reminding the resident to use her call light. On September 5, at 11:36 a.m. a post incident follow-up three days later indicated R1's husband reported she had increased pain in her right leg and knee since the fall incident. The note indicated R1's right knee was considerably larger than the left knee, and R1 winced with pain when it was extended slightly. On September 6, 2023, at 6:06 p.m. a radiology report indicated an X-ray was obtained four days after the provider orders were placed for evaluation of R1's pain and swelling. The radiology report indicated R1 had suspicious findings of an acute significantly displaced fracture of her right distal femur. On September 7, 2023, at 3:00 p.m. R1's outside medical record hospice progress note indicated the resident was admitted to the hospital for fracture management and pain control. R1's medical record indicated her plan of care including care, services, and supervision were not provided at the time of the falls. R1's September 2023, document titled "scheduled services report" included scheduled supervision "courtesy visits" (safety checks) 11 times daily, scheduled about every two hours. The service record had numerous scheduled times when courtesy visits were not provided to R1. The service report indicated the day of the first incident, R1 was scheduled to have a courtesy visit at 2:00 a.m. but one was not completed. R1 was found on the floor 30 minutes later. In addition, no courtesy visits were provided as scheduled to the resident	02310		

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02310	Continued From page 5 after the fall occurred, then the second fall incident occurred six hours later at 8:40 a.m. The following day R1 received no courtesy visits as scheduled from 8:00 a.m. till 10:00 p.m., then R1 was again found on the floor at 10:30 p.m. The services report failed to include scheduled toileting or incontinence care every two to three hours as indicated in R1's care plan when the falls occurred. On December 13, 2023, at 9:37 a.m. registered nurse case manager (RNCM)-A stated R1 had no history of falls at the time of admission. R1 required assistance from one to two staff toileting and incontinence care every two hours. RNCM-A stated the staff went by the services checklist to know what to do for each resident. Then RNCM-A reviewed R1's services and verified R1 had no services for toileting and incontinence care scheduled at the time of the incidents. RNCM-A stated, "staff knew they were supposed to do it every two hours". RNCM-A stated the resident had three falls in two days with no concerns of injury, then three days later R1's husband reported she had increased pain and swelling since the fall. RNCM-A indicated an X-ray was ordered which identified a right distal femur fracture. On December 13, 2023, at 10:25 a.m. registered nurse [director of nursing] (RN)-B stated R1 was cognitively impaired, non-verbal, incontinent, and dependent on staff for assistance with toileting and incontinence cares every two hours. RN-B stated the resident's services should include scheduled toileting and incontinence care, and verified they did not until the resident was readmitted to the facility on September 14, 2023. RN-B stated a courtesy visit was when staff check on a resident, and indicated a courtesy visit	02310		

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02310	Continued From page 6 was not the same as scheduled toileting or incontinence cares. RN-B stated R1's assessment populated into the care plan, then the services were added manually into Rtasks for staff to implement. RN-B indicated R1's services for toileting and incontinence care must have been missed. RN-B indicated R1 had no complaints of pain and no concerns of injury till September 5, 2023, several days after the falls occurred, then an X-ray was ordered which found R1 had a distal femur fracture. On December 13, 2023, at 11:39 a.m. unlicensed personnel (ULP)-D stated R1 needed toileting, and incontinence care every two hours. ULP-D indicated if a required service was not on the resident's services checklist to document as completed, he would notify the nurse to add it. ULP-D indicated there were no new interventions added after R1's falls. On December 13, 2023, at 11:57 a.m. ULP-E stated R1 did not have scheduled toileting or incontinence cares, and indicated she provided incontinence care at the start of her shift and after meals. ULP-E stated after R1 fell she had increased difficulty bearing weight on her right leg. ULP-E stated R1 had pain and would cry every time her leg was moved before she went to the hospital. ULP-E stated she reported R1's pain to nursing. ULP-E stated she witnessed R1 wearing the same clothing from the previous day that was completely saturated with urine into her bedding, and it appeared R1 had not been checked on for some time. ULP-E stated a courtesy visit included checking on the resident, and if a resident required toileting or incontinence care that would be a separate scheduled service. On December 26, at 11:03 a.m. licensed practical	02310		

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02310	Continued From page 7 nurse (LPN)-F stated R1 required toileting and incontinence care every two hours, and indicated a courtesy visit was a safety check and different than a scheduled toileting or incontinence care service. LPN-F stated he was called to R1's room after staff found her lying on the floor beside her bed on September 2, 2023, at 10:25 p.m. LPN-F stated R1 was grimacing in pain, and guarding her right knee/leg after the fall occurred. LPN-F stated R1 had "no bones protruding from her leg", so R1 was assisted back to bed. LPN-F stated R1 had no fall mat in place at the time of the fall, and R1 was reminded to use her call light to prevent recurring falls. On December 26, at 8:55 a.m. LPN-G stated three days after R1's last fall, on September 5, 2023, he completed a post incident fall follow up, and R1's husband reported she had increased pain and swelling in her right knee/leg since the fall. LPN-G indicated a post fall assessment should be completed each shift for three days after a fall occurred. LPN-G indicated R1 was having pain and swelling, and indicated the X-ray ordered should have been completed right away. LPN-G stated the clinical manager was responsible to make sure the X-ray was done timely. LPN-G stated R1's services should have specified R1 needed assistance with toileting and incontinence care every two hours. LPN-G stated the facility did not have enough staff to check on and provide cares to R1 every two hours. On December 26, 2023, at 10:12 a.m. ULP-I stated she had observed R1 soaked with urine and feces when coming on shift and it appeared as though R1 had not been checked on for some time. ULP-I stated after R1 fell she had pain and difficulty with transfers. ULP-I stated a courtesy visit was when you visualize and check on the	02310		

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02310	Continued From page 8 resident to make sure they are safe. On December 26, 2023, at 10:47 a.m. ULP-J stated after the fall R1's knee was very painful, stiff, bruised, and swollen. ULP-J indicated she was scared and nervous to move the resident before they knew her femur was broken because she was in so much pain. ULP-J stated R1 was not able to bear weight on that leg after the incident occurred. A facility policy and procedure titled "Fall Prevention and Management" reviewed on December 8, 2023, indicated the RN would complete a post fall analysis to determine the cause of the fall, if current interventions were effective, and if other possible interventions should be used, they would be added to the resident's care plan. A facility policy and procedure titled "Fall Management" reviewed October 31, 2021, indicated the purpose was to ensure residents who sustain a fall were appropriately assisted by the care specialist. Section 8 indicated if the resident reported pain or had nonverbal signs of pain including facial grimacing, the resident would not be moved but 911 would be called. Section 10. indicated if at any point the resident reported pain when assisting off the floor they would be gently lowered, and 911 would be called. A facility policy and procedure titled "Service Plans and Care Plans" reviewed December 8, 2023, indicated the RN would update the resident's services as needed with a resident's change in needs or condition. The services guide instruct staff in how to care for the resident. The residents service plan must include a description of the services and frequency of each service	02310		

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02310	Continued From page 9 provided. A facility policy and procedure titled " Accident/Incident Reports" reviewed December 8, 2023, indicated if a resident sustained a fall the RN would be notified, and incident report would be completed with a summary of details including contributing factors, cause, and any injuries. Interventions to prevent recurring falls would be implemented immediately, and interventions would be added to the resident's services. The residents fall would be added to the problem list for monitoring, and providers orders would be processed. A facility policy and procedure titled "Nursing Assessment" dated November 26, 2023, indicated the RN would complete an assessment with any change of condition, or adverse event including a fall and would update the residents service plan. A facility policy and procedure titled "Client Record Documentation" revised October 21, 2021, indicated staff would document on a daily basis the provision of services provided to the client including the date and time. The policy and procedure instructed staff to document the reason services were not provided and indicated they would be followed up on. A facility policy and procedure titled "Medication and Treatment Orders" revised December 17, 2023, indicated a provider's order would be implemented within 24 hours. No additional information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		

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 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: Based on observations, interviews, and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was neglected. 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		