Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL299118546M
Compliance #: HL299115927C

Date Concluded: March 5, 2024

Name, Address, and County of Licensee Investigated:
Woodstone Senior Living
1025 Dale St SW
Hutchinson, MN 55350
McLeod County

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the alleged perpetrator (AP) failed to provide care, services, and supervision as indicated in the resident's service/care plan. After the resident fell, the AP failed to check on the resident, as a result the resident laid on the floor for 6 hours. The resident was transferred to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The resident fell at 8:29 p.m. The AP came on shift at 10:00 p.m. The AP failed to completed wellness checks on the resident. The resident was found on the floor in her room six hours after the fall. The resident was sent to the emergency room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, and the resident's family members. The investigation included review of the resident record(s), hospital

records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, video evidence, and related facility policy and procedures. Also, the investigator observed resident's and staff in the facility.

The resident resided in an assisted living facility secure memory care unit with diagnoses including Alzheimer's Disease, dementia, and anxiety.

The resident's assessment indicated the resident was severely cognitively impaired, disoriented to person, place, time, and unable to use a call light system to alert staff or communicate her needs. The assessment indicated staff would provide routine wellness checks on the resident.

The resident's individualized abuse prevention plan (IAPP) indicated the resident was at risk for abuse and neglect secondary to impaired cognition. The IAPP indicated staff were to provide wellness checks per service plan, anticipate the resident's needs, and report any concerns to the nurse. The IAPP identified the resident had electronic monitoring in her room which recorded video and audio.

The resident's service/care plan identified the resident was at a risk for falls, unable to use a call light system to alert staff in the event of an emergency, and indicated staff were to complete wellness checks 7 times daily including times scheduled at 10:00 p.m. and 12:00 a.m. during the AP's shift.

A facility incident report indicated during change of shift quality rounds at 2:30 a.m. the resident was found lying face down on the floor next to her bed. The resident complained of pain and was transferred by ambulance to the emergency department (ED) for evaluation and treatment.

The ED and hospital record indicated the resident had an unwitnessed fall and was found on the floor during rounds. The record indicated the resident had extensive imaging with no evidence of acute traumatic injury or fractures. The record indicated the resident had a transient elevation in her creatinine kinase (CK) blood test (a possible indicator of skeletal muscle damage or degeneration) which resolved with intravenous fluids.

The resident record indicated the night of the incident the resident refused assistance with evening cares. The resident record indicated the AP documented completing wellness checks at 10:39 p.m., and 12:26 a.m. In addition, the AP documented completing a change of shift quality check on all residents on the unit at 11:05 p.m. The resident record indicated the resident had no other scheduled services between the evening cares (documented as refused) and the first wellness check scheduled at 10:00 p.m. on the AP's shift.

The facility investigation indicated the AP was scheduled to work on the secure memory care unit from 10:00 p.m. till 2:00 a.m. The investigation indicated the AP documented completing wellness checks on the resident, but the resident's continuous electronic video monitoring

system showed no checks were completed. As a result, the resident was not found by staff until change of shift quality rounds at 2:30 a.m. When interviewed by facility leadership the AP stated she did not complete change of shift quality rounds at 10:00 p.m. because staff told her everyone was in bed. The facility investigation indicated the AP was unable to recall if she opened the top of the resident's door around 12:00 a.m. to complete a wellness check or not, and stated, "I know I should have gone all the way in". The facility investigation indicated surveillance cameras from common areas were reviewed by leadership staff during the time of the incident and showed none of the wellness checks were completed by the AP.

A police report, officers body camera video interview with the AP, and images/videos provided indicated the AP told the officer that she assumed her duties at the start of her shift at 10:00 p.m. and change of shift quality rounds and wellness checks were her responsibility at that time. The AP verified she documented completing change of shift quality rounds but did not do them. The AP stated she "should have checked on the resident, no one deserved to lay on the floor that long". During the interview with law enforcement the AP stated she had documented completing the checks but did not check on the resident. The police report indicated video footage provided by the resident's family was reviewed and the resident was observed to fall on the floor around 8:30 p.m., with no staff observed enter the resident's room until 2:30 a.m., 6 hours after the resident fell.

When interviewed the AP stated she completed a wellness check on the resident around 12:00 a.m., opened the top portion of the resident's door a little bit, and saw the resident laying in her bed under the covers with the lights in her room off. The AP indicated she was not responsible for neglect because the resident fell before her shift started. The AP admitted she did not complete wellness checks as documented.

When interviewed several facility staff stated they always completed change of shift quality rounds to ensure all residents were ok at the start of each shift. One staff stated the night of the incident the AP refused to complete change of shift quality rounds because she was "tired and had just finished working an evening shift on another unit". Although the change of shift rounds was not completed, the AP was assigned to perform a wellness check on the resident at 10:00 p.m. per the service agreement and care plan and admitted she did not.

When interviewed facility leadership stated the AP was the only staff assigned to work the secure memory care unit from 10:00 p.m. until 2:00 a.m. Leadership staff stated the AP was assigned to complete the change of shift quality rounds at 10:00 p.m. but did not do them. Leadership staff stated when they reviewed facility surveillance video, the AP was observed sitting in the common area at the times wellness checks were documented.

A review of continuous video footage from the video monitoring system in the resident's room showed the resident's room lights on, her bed made, and the resident's door closed. The resident was observed fully dressed laying on top of her made bed, not under the covers as the AP stated she observed during wellness rounds. The resident was observed to fall at 8:29 p.m.,

and the AP never completed checks on the resident as documented. The video does not show the AP cracking the top of the resident's door open as stated, or at any point prior to the resident being found by staff at 2:30 a.m., 6 hours after the resident fell. Discrepancies in the AP's statements, and what was observed on the video footage indicated the AP did not complete any of the wellness checks on the resident as documented or as stated.

When interviewed the resident's family members stated the resident fell, was unable to get up, and was heard calling out for help until staff found her 6 hours later. The family stated the ED provider reported the resident had abnormal lab values caused by muscle damage from the resident laying on the floor for a prolonged period of time.

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, unable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP pending investigation of the incident and reported to the common entry point Minnesota Adult Abuse Reporting Center (MAARC). The facility investigated the incident, provided education to all staff on completing wellness checks and reporting/investigating maltreatment. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
McLeod County Attorney
Hutchinson City Attorney
Hutchinson Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29911	A. BUILDING: _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	1025 DALE STREET SW HUTCHINSON, MN 55350

(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: #HL299118546M/# HL299115927C 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 37 residents receiving services under the provider's Comprehensive Assisted Living license. The following correction orders are issued for #HL299118546M/# HL299115927C, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 1 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 an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		