Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL299134403M
Compliance #: HL299137418C

Date Concluded: October 10, 2023

Name, Address, and County of Licensee Investigated:
Woodstone Senior Living
2020 Meyer Drive
New Ulm, MN 56073
Brown County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 the resident when staff failed to follow the resident's plan of care and served food that was not a part of the resident's prescribed diet.

In addition, the facility neglected the resident when the alleged perpetrator (AP), a registered nurse (RN), failed to report, assess, and monitor a change in condition. The resident was admitted to the hospital with aspiration pneumonia and died approximately two weeks later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The on-call registered nurse (RN)/alleged perpetrator (AP) failed to appropriately assess the resident's change in condition and failed to respond to reports of oxygen saturation levels below normal ranges. The resident experienced low oxygen saturation levels around 70% to 80% (normal range is 90%-100%) for almost 24 hours. Unlicensed personnel (ULP) reported abnormal oxygen saturation levels to the on-call RN, but a physician was not updated, and no action was taken.

However, the resident's daughter requested staff to call the facility nurse later that day, who directed the resident be sent to the emergency room. The resident was hospitalized with aspiration pneumonia and a COPD exacerbation and returned to the facility on hospice services. The resident died approximately two weeks later of aspiration pneumonia. The resident was hospitalized two weeks prior to this incident for aspiration pneumonia after experiencing abnormal oxygen saturation levels. Since the resident had two prior hospital admissions with aspiration pneumonia as the admitting diagnosis, it is unable to be determined if the delay in care from the on-call RN directly led to the resident's death. Additionally, the resident was fed food that was not part of his prescribed diet, however he began to show symptoms of aspiration pneumonia prior to being served the incorrect diet. Dietary staff was appropriately trained on preparing modified diets and re-trained following the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the hospital. The investigation included review of the resident's hospital medical records, death certificate, and facility records including the service plan, recent assessments, progress notes, and care plan.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included Alzheimer's dementia with behavioral disturbance, congestive heart failure, and chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with dressing, grooming, toileting, behavior management, and medication administration. The resident's assessment indicated the resident was to have thickened liquids and soft, bite-sized food. The resident had been hospitalized recently with a diagnosis of aspiration pneumonia.

Approximately three weeks before the resident's death, he was sent to the hospital with low oxygen saturation levels and complaints of shortness of breath. The resident was admitted with a diagnosis of aspiration pneumonia and COPD exacerbation. Hospital records indicated the resident had extensive coughing with food intake, required suctioning, and a speech therapy evaluation was ordered by the physician. Speech therapy recommended a level 6 dysphagia diet (soft/bite sized food) with nectar thick liquids. The resident was treated with supplemental oxygen at the hospital but was weaned off the supplement oxygen prior to his discharged back to the facility.

Approximately ten days after returning from the hospital, the resident was noted to have a lingering, non-productive cough and became short of breath with transfers and coughing. The facility RN contacted the resident's home health nurse on a Friday with her concerns and informed the RN the resident's cough was not improving. A progress note indicated the home care RN replied she "would send a message back to his provider but could not guarantee an answer today due to it being Friday of a holiday."

Two days later, on a Sunday morning, ULP contacted the facility on-call RN after the resident's oxygen saturation levels ranged from the mid-70s to mid-80s. A facility incident report indicated the resident didn't have an order for oxygen to be applied, so the on-call RN instructed ULP to

give PRN (as needed) Tylenol or an inhaler. The resident did not have a physician’s order for Tylenol and the inhaler was out of doses. The on-call RN encouraged ULP to call the resident’s daughter to see if she could bring a different inhaler so they could alternate administration of PRN inhalers and PRN nebulizers. The resident continued to have oxygen saturations in the low 80s and the on-call RN was contacted again. The on-call RN instructed ULP to call her if the resident's oxygen got as low as 75% or if his face, lips, or fingers became blue.

The resident's family came into the facility to visit before lunch and commented the resident "looked rough and was debating bringing him in to the ER..." The resident was served corn at lunch, which was not a part of the resident’s prescribed diet. The resident was also served a dish with corn in it again at supper. After supper, the on-call RN was called again, and ULP were advised "family needs to decide if they want him to go in or not when they come in but the PRNs were not helping." The resident’s family came back to the facility after supper with an inhaler for the resident. The family questioned why the resident was not put on oxygen and if the facility had a portable oxygen machine for him. ULP told the resident’s daughter they didn’t have an oxygen machine and “explained what the on-call RN had stated.” The resident’s daughter requested ULP call the facility RN, instead of the on-call RN, for further guidance. The facility RN noted she could “hear the resident's coughing in the background, noting that the PRNs were not helping, and the resident was telling his family "goodbye" and that he “didn't want to fight anymore." The facility RN encouraged the family to take the resident to the hospital.

Facility documentation indicated the on-call RN reported she "received numerous phone calls throughout the weekend regarding [the resident] and his coughing but nothing was helping." The on-call RN apologized for not sending the resident in but "didn't know if family wanted him to go in as staff had not related that information about talking to family."

During an interview, the on-call RN stated she worked as an on-call nurse for the facility, took call every third weekend, but did not work in the facility and worked at a hospital for her primary job. The on-call RN stated while on call, she did not have access to the resident's electronic medical record and relied solely on what ULP reported over the phone. The on-call RN stated ULP were “usually pretty good” and she knew to ask detailed questions to obtain all the information she needed to triage and assess the issue. The on-call RN stated any information she needed to triage an issue could be obtained verbally and she did not need to access the resident's medical record. The on-call RN trusted the assessment and judgment of the ULP. The on-call RN stated she was updated by the facility RN, before she took over call for the weekend, that the resident was hospitalized two weeks prior for aspiration pneumonia and had a persistent cough. The on-call RN stated it was not unusual for someone with pneumonia to have a lingering cough and besides low oxygen, the resident’s other vital signs were within normal limits. The on-call RN stated since the resident was stable enough to be discharged from the hospital and was not discharged with supplemental oxygen, she initially wasn't too concerned. The on-call RN stated she "didn't know if he was one of those people who didn't maintain his oxygen sats since he recovered, I have in my notes he would be 79% and would

improve to 89%, but his temp was still 98. In hindsight, even though he recovered, I should have sent him in." The on-call RN stated she instructed staff to complete breathing exercises with the resident while she was on the phone with them, and his oxygen saturations would come back to the high 80s so, "I thought we'll just keep working with him to keep him at the facility." The on-call RN stated if the resident's temperature was out of normal range or if his vitals had been different, "I would have immediately sent him in." The on-call RN thought staff had called her about three times over the course of the day to report issues with the resident maintaining his oxygen saturation levels.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Attempts made were unsuccessful
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the incident to MAARC and the on-call RN was retrained. Dietary staff were also retrained on appropriate diets.

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.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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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: #HL299134403M/#HL299137418C On August 22, 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 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL299134403M/#HL299137418C, tag identification 2320.	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.	
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health	02320		

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02320	Continued From page 1 care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident received health care services from people who were competent, when the facility on-call registered nurse (RN)-A failed to assess and monitor a resident's change in condition for one of one residents (R1) reviewed. 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: The facility on-call RN (RN-A) failed to appropriately assess R1's change in condition and respond to reports of oxygen saturation levels below normal ranges. R1 experienced oxygen saturation levels around 70% to 80% (normal range is 90%-100%) for almost 24 hours. Unlicensed personnel (ULP) reported abnormal oxygen saturation levels to RN-A on December 25, 2022. RN-A failed to report the abnormal oxygen saturation levels to a physician. The resident was sent to the emergency room after	02320		

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02320	Continued From page 2 R1's daughter requested ULP to contact the facility's primary registered nurse (RN)-E. The resident was hospitalized with aspiration pneumonia and a COPD exacerbation and returned to the facility on hospice. The resident died approximately two weeks later of aspiration pneumonia. R1's diagnoses included Alzheimer's dementia with behavioral disturbance, congestive heart failure, and chronic obstructive pulmonary disease (COPD). R1's service plan, dated December 16, 2022, indicated the resident received assistance with dressing, grooming, toileting, behavior management, and medication administration. R1's care plan, dated December 16, 2022, indicated the resident's diet included "mildly thick liquids and soft bite sized food." The resident needed to be encouraged to eat slowly and take his time chewing and swallowing. The care plan indicated the resident was hospitlized from December 11, 2022, through December 14, 2022, for COPD exacerbation and had been weaned off oxygen therapy. On December 11, 2022, the resident was sent to the emergency room after having shortness of breath and low oxygen saturations. A progress note indicated R1 was noted to be coughing and struggling to breathe with oxygen saturation levels ranging between 84% and 90%. RN-E advised the resident be sent to the emergency room via ambulance and the resident was admitted with COPD pneumonia. Hospital records indicated R1 was admitted to the hospital on December 11, 2022, and diagnosed	02320		

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02320	Continued From page 3 with COPD exacerbation and aspiraion pneumonia. It was noted the resident had extensive coughing with food intake which required suctioning so a speech therapy evaluation was ordered for the resident. Speech therapy recommended a level 6 dysphagia diet (soft/bite sized food) with nectar thick liquids. The resident was treated with supplemental oxygen at the hospital but was weaned off by the time he discharged back to the facility. R1's hospital discharge orders, dated December 14, 2022, included an order for a suction machine to be used as-needed when not able to swallow secretions. The resident was also prescribed a nebulizer to use for seven days, a cough medication to use for up to 14 days, two different antibiotics to take for five days, an inhaler to use for 14 days, and a steroid to take for three days. On December 14, 2022, R1 returned from the hospital with a suction machine. The progress note indicated RN-E was not aware the resident was returning with suctioning ordered and "due to facility not providing services for suctioning, writer reached back out to the hospital SW [social worker]" The hospital social worker indicated she was not aware suctioning had been ordered, but the resident had been using it on his own in the hospital and it was to be used as-needed. RN-E noted she informed the hospital social worker that the resident wasn't able to suction himself and was told home care/speech therapy would assess him and to put the suctioning on hold for now. RN-E documented the resident's diet was now soft, bite-sized and mildly thick liquids and the resident needed to be encouraged to eat slowly and swallow his food before taking another bite. Speech therapy evaluated the resident again on	02320		

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02320	Continued From page 4 December 18, 2022, and noted the resident would continue on nectar thick liquids with soft, bite-sized foods. On December 20, 2022, the resident was noted to have a frequent, non-productive cough with oxygen saturations 86% on room air. On December 22, 2022, the resident was seen by the home care nurse and was noted to have a non productive, congested, cough and would become short of breath with transfers and coughing. A progress note entered on December 27, 2022, but backdated to December 23, 2022, indicated on December 23, 2022, RN-E reached out to the home care RN regarding the resident's cough and that it wasn't improving with medication changes. The progress note indicated the home care RN "would send a message to his provider but could not guarantee an answer today due to it being Friday of a holiday." The facility's on-call RN schedule indicated RN-A was the nurse on call for the weekend of Saturday, December 24, 2022, and Sunday, December 25, 2022. A progress note entered on December 27, 2022, but backdated to December 25, 2022, indicated on December 25, 2022, at 6:27 a.m., RN-E received a message in the electronic medical record from the overnight shift at 3:23 a.m., informing her the resident had a nebulizer treatment at 11:49 p.m.. for oxygen saturations between 79% and 83%. The resident was noted to be "very out of it, staff had to hold the mouth piece up to his mouth and talk to him to keep him awake for the treatment. Is not coughing but can	02320		

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02320	Continued From page 5 hear occasional audible wheezing and gurgle of phlegm in his throat. No improvement from neb. On call RN [RN-A] called at 11:50 p.m., She directed to give PRN [as needed] inhaler at 11:52 p.m. No improvement from inhaler. Oxygen saturations remain between 79% and 83%. Staff called [RN-A] again at 12:50 a.m. to update on resident's condition. [RN-A] said to monitor the color of his lips/nail beds and to call if oxygen saturations get 75% or lower. Said to let him sleep and see how he is in the morning." A progress note entered on December 27, 2022, but backdated to December 25, 2022, indicated on December 25, 2022, at 6:03 p.m., RN-E received a phone call from the facility after ULP-C was concerned about the resident's condition and constant coughing. RN-E instructed ULP-C to call the ambulance. The resident was sent to the hospital for further evaluation. R1's hospital admission history and physical from December 25, 2022, indicated the resident was admitted to the hospital with aspiration pneumonia. The physician's note indicated the resident "was hospitalized from December 11, 2022, through December 14, 2022, and ...was evaluated by speech therapy and recommendations were made for a level 6 dysphagia diet as well as nectar thick liquids. He was discharged back to his facility. His daughter who is at the bedside is concerned that the facility has not updated the patient's diet, and he continues to receive regular diet. She was informed that he has been experiencing a worsening cough and shortness of breath over the past 2 weeks. Last evening he had oxygen levels as low as 77% on room air. His cough and low oxygen saturation persisted and thus he was brought to the ED for further evaluation.	02320		

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02320	Continued From page 6 According to the ED [emergency department] provider when he arrived a large amount of food was present within the oropharynx (middle of the throat) and aggressively suctioned. The resident was discharged back to the facility on December 30, 2022, with hospice services. A progress note entered on December 27, 2022, indicated on December 26, 2022, RN-E spoke with the resident's daughter who informed her the resident "needed to have deep suctioning done and they removed corn and ground beef from his lungs." A progress note entered on December 30, 2022, indicated RN-E contacted corporate staff on December 28, 2022, and were advised to submit a MAARC report, follow up with staff from all shifts, and follow up with RN-A regarding oxygen saturations and to provide education with her on triaging. On December 28, 2022, RN-E documented a description of the December 25, 2022, incident from two ULP working that day. ULP-C stated she called RN-A after the resident had a cough and had an oxygen saturation level of 84% on room air. The resident had already used a PRN cough medicine so she called the on-call nurse for further guidance. RN-A instructed ULP-C to give tylenol or an inhaler. The resident did not have a PRN tylenol order and the PRN inhaler was out of doses. ULP-C was encouraged to call the resident's daughter to see if she could bring in a different inhaler, but she did not answer and didn't call back until right before supper. The resident ate some tator tot hotdish and then went to lay down in his bed. After supper, the on-call nurse, RN-A, was called again and staff were advised that "family needs to decide if they want him to go	02320		

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02320	Continued From page 7 in or not when they come in but the PRNs were not helping." After supper, R1's daughter arrived and questioned why he was not put on oxygen and if the facility had a portable oxygen machine for him. ULP-C told the resident's daughter they didn't have an oxygen machine and "explained what the on call RN had stated." The daughter requested they call RN-E instead. RN-E documented she could hear the resident's coughing in the background, noting that the PRNs were not helping and he was telling his family "goodbye" and that he "didn't want to fight anymore." RN-E encouraged the family to take the resident to the hospital. Documentation of RN-E's follow up with RN-A on December 28, 2022, indicated RN-A stated the resident's oxygen levels were ranging anywhere from 79% to 89% on room air and he didn't have an order for oxygen to be applied so she instructed staff to use PRN inhalers and PRN nebulizers. RN-A stated the resident's oxygen levels were jumping around and she wanted to monitor to see if anything would improve with PRN inhaler and nebulizer use. RN-A told RN-E she "received numerous phone calls through the weekend regarding [R1] and his coughing but nothing was helping." RN-A apologized for not sending the resident in but "didn't know if family wanted him to go in as staff had not related that information about talking to family." The facility incident report indicated the resident's oxygen saturation levels ranged from 79% to 89% on room air early Sunday morning, December 25, 2022. Unlicensed personnel contacted the on-call RN, RN-A, and RN-A instructed staff to alternate between a PRN inhaler and PRN nebulizer for relief. The resident continued to have low oxygen saturations in the low 80s, and RN-A was	02320		

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02320	Continued From page 8 contacted again. RN-A instructed staff to call her if the resident's oxygen got as low as 75% or if his face, lips, fingers became blue. The resident's family came in to visit before lunch and commented he "looked rough and was debating bringing him in to the ER..." The resident was served corn at lunch. The evening shift came on and the resident was noted to have 84% oxygen saturations on room air On August 25, 2023, at 1:15 p.m., RN-E stated R1 had a "huge decline" after he returned from the hospital on December 14, 2022, and continued to have a cough through the time he returned to the hospital on December 25, 2022. RN-E stated R1 began to have low oxygen levels in the upper 70s to upper 80s in the early hours of December 25, 2022, but the on-call nurse didn't want to send him in right away since the oxygen saturation levels were so variable. RN-E stated she was called the evening of December 25, 2022, after R1's daughter requested staff call her instead of RN-A. RN-E stated "I do know all the residents on a different level than the on-call staff since I'm here in person five days a week. I could hear him coughing in the background...I encouraged them to send him to the emergency room since he hadn't had any improvement in a 24 hour period." On August 25, 2023, at 4:45 p.m., RN-A stated she worked as an on-call nurse for the facility and took call every third weekend but did not work in the facility and worked at a hospital for her primary job. RN-A stated while on call, she did not have access to the resident's electronic medical record and relied solely on what unlicensed staff reported over the phone. RN-A stated the unlicensed staff were usually pretty good and she knew to ask detailed questions to obtain all the	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29913	A. BUILDING: _____ B. WING _____	C 08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTONE SENIOR LIVING	2020 MEYER DRIVE NEW ULM, MN 56073

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02320	Continued From page 9 information she needed to triage and assess the issue and any information she needed to triage the issue could be obtained verbally and she did not need to access the resident's medical record. RN-A stated she trusted the assessment and judgment of the unlicensed staff. RN-A stated she had been updated by RN-E before she took over call that R1 was hospitalized about two weeks prior to the incident for aspiration pneumonia and had a persistent cough. RN-A stated it was not unusual for someone with pneumonia to have a lingering cough and besides low oxygen, the residents other vital signs were within normal limits. RN-A stated since the resident was stable enough to be discharged from the hospital and was not discharged with supplemental oxygen, she initially wasn't too concerned. RN-A stated she "didn't know if he was one of those people who didn't maintain his oxygen sats since he recovered, I have in my notes he would be 79% and would improve to 89% but his temp was still 98. In hindsight, even though he recovered, I should have sent him in." RN-A stated she instructed staff to do breathing exercises with the resident while she was on the phone with them and his oxygen saturations would come back to the high 80s so "I thought we'll just keep working with him to keep him at the facility." RN-A stated if the resident's temperature was out of normal range or if his vitals had been different, "I would have immediately sent him in." RN-A thought staff had called her about three times over the course of the day to report issues with maintaining oxygen saturation levels. The licensee's undated procedure of 'When to contact the R.N.' indicated staff were to contact the RN if the oxygen saturation is 90% or below unless otherwise stated per the RN.	02320		

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02320	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		