Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302469226M
Compliance #: HL302466909C

Date Concluded: March 6, 2024

Name, Address, and County of Licensee Investigated:
Regina Assisted Living
1008 1St St W
Hastings, MN 55033
Dakota County

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

Evaluator's Name: Deb Schillinger, 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 neglected the resident when the facility did not address the resident's risk for falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did fall and sustain a broken hip and a subdural hematoma (bleeding in the brain), the facility had taken reasonable steps to prevent falls. Additionally, when the resident was injured, the facility acted appropriately by transferring the resident to the hospital to address his injuries and increased pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and hospice caregivers. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, staff schedules, related facility

policy and procedures. Also, the investigator toured the facility and observed interactions between facility staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia, myelodysplastic syndrome (a type of cancer which can affect blood clotting), and osteopenia (a condition which makes bones weaker). The resident's service plan indicated the resident required assistance of one person for toileting and mobility along with safety checks. The resident's assessment indicated he ambulated with a walker but had confusion and was oriented only to self. The resident was also enrolled in a hospice program.

A few days after the resident admitted to the facility, the progress notes indicated an unlicensed caregiver found the resident on the floor during safety rounds at 4:30 a.m. bleeding and complaining of pain. The unlicensed caregiver called 911 to transfer the resident to the emergency department for evaluation and updated the on-call nurse.

The hospital records indicated the resident was admitted to the hospital with a subdural hematoma (bleeding on the brain) and a broken hip. The same records indicated the hospital administered intravenous pain medications to treat the resident's hip pain. The hospital was unable to contact family for three hours as the facility did not send medical records with the resident to the hospital. When the hospital did reach the family, the family member relayed the resident had been on hospice care and requested aggressive treatments be stopped. The resident admitted to the hospital for comfort cares and died four days later.

During an interview, the unlicensed caregiver stated she had been trained to call 911 if a resident had a serious fall. She said the resident's fall, injuries, and pain seemed serious, so she called 911 and then the on-call nurse.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided re-training regarding communication regarding fall follow-up, providing records and communications to hospitals during training, and contacting family members with updates for both licensed and unlicensed caregivers.

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
	30246	A. BUILDING: _____ B. WING _____	C 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA ASSISTED LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 January 31, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL302466909C/#HL302469226M. No correction orders are issued.	0 000		