Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303277604M
Compliance #: HL303274264C

Date Concluded: August 24, 2023

Name, Address, and County of Licensee Investigated:
Nelson Gables
1220 Nokomis Street
Alexandria, MN 56308
Douglas County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the facility failed to ensure fall interventions were implemented to prevent falls. The resident transferred without staff assistance and was found in the bathroom with a facial laceration, head injury, and no pulse. The resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident's bed safety device (a pressure mat on the bed that alarms if pressure is removed from the pad) failed to alert staff when the resident transferred herself to the bathroom and fell. It could not be determined if the device was placed correctly at the time of the fall, nor could it be determined if the residents fall could have been prevented if the device had alerted staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member, law enforcement, and reviewed the police report. The investigation included review of resident

records including assessments, care plan, call light reports, safety device reports, record of death, facility investigation documentation, employee records, and facility policies and procedures. Also, the investigator observed the bed and chair safety device system used in the facility.

The resident resided in an assisted living facility with diagnoses including heart failure, chronic kidney disease, atrial fibrillation (irregular heartbeat), and stroke.

The resident assessment indicated the resident was receiving hospice end of life care. The assessment indicated the resident was alert, oriented, and could make her needs known. The resident could be resistive to receiving staff assistance which contributed to frequent falls, and identified other factors including positional vertigo, weakness, and hypoxemia (low oxygen in her blood) which also increased her risk for falls. The assessment indicated the resident required assistance from one staff with transfers, ambulation, and toileting needs.

The resident's care plan indicated the resident was at a risk for falls related to a history of frequent falls and transferring/walking without staff assistance. The care plan had various fall interventions including a bed safety device used to alert staff if the resident transferred/walked without assistance. The care plan indicated the resident also utilized a pendant call light system to summon staff assistance.

A review of the resident's call light and safety device alarm reports indicated the device was activated one time prior to the incident. The report indicated the resident had not summoned staff for assistance, and the safety device did not alert staff at the time of the incident.

A facility incident report indicated the resident was found on the bathroom floor, warm to the touch, not responsive, with signs of trauma to her head and face, and no pulse.

A fall progress note indicated when staff responded to a neighboring call light, they noticed the resident's bedroom light was on. Staff entered the room to check on the resident and found her on the floor deceased. The progress note indicated staff responded to the resident's safety device earlier in the night, but the resident denied needing anything at that time. The progress note indicated staff reset the device, turned off the resident's lights, and left the room. The progress note indicated staff had not verified placement of the safety device when it was reset.

When interviewed facility staff stated the resident's safety device had not alerted them when the resident went to the bathroom without assistance. Staff stated they called for help and contacted the nurse immediately after the incident occurred.

The resident's death record indicated trauma or injury did not contribute to the resident's death.

When interviewed the resident’s family member denied any concerns of neglect and indicated she felt the facility had taken all precautions to help prevent recurring falls.

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: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility investigated the incident and reported the concern to the common entry point.

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
	30327	A. BUILDING: _____ B. WING _____	C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON GABLES	1220 NOKOMIS STREET ALEXANDRIA, MN 56308

(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 August 8, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL303277604M/#HL303274264C. No correction orders are issued.	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.	