Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304347908M
Compliance #: HL304344835C

Date Concluded: April 5, 2024

Name, Address, and County of Licensee Investigated:
Saint Ann's Home
330 East 3rd Street 218
Duluth, MN 55805
St Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 abused the resident when they physically restrained the resident in bed with bilateral siderails. Staff found the resident with his head stuck between the bed side rail and mattress.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The nursing assessment identified the resident was not cognitively and physically able to use the side rail safely as a mobility aide and the facility neglected to remove the side rail. In addition, ULP failed to provide any services for eight hours prior to the morning ULP finding the resident stuck with his head between the mattress and side rail. Unlicensed personnel (ULP) said the side rails were used to keep the resident from falling out of bed which conflicted with a nurse report the resident used side rail when staff assisted with transfers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed residents who used side rails.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and major depressive disorder. The resident's service plan included assistance with toileting, medication management and behavior monitoring. The resident's assessment indicated he required help with sitting up in bed and used a walker with supervised walking. The resident's cognition was alert and oriented to self with moderately impaired decision-making ability.

The resident received an electric hospital bed with side rails when he began hospice services at the facility. The resident's side rail assessment indicated the resident was unable to walk, had fluctuating consciousness, and alteration in safety awareness due to cognitive decline. Additionally, the assessment indicated the resident was not using the side rail for positioning or support and had a history of falls. The side rail assessment indicated the right side rail was used and lacked side rail measurements required by the FDA (Food and Drug Administration).

The resident's service delivery record indicated he had scheduled evening cares and toileting at 9:00 p.m. He had scheduled toileting during the night at 1:00 a.m. and 5:00 a.m. The service delivery record also had once per shift a sign off for completing scheduled ULP visit (safety checks). The first service for the day shift was scheduled at 9:00 a.m. for morning cares.

The facility investigated the incident and reviewed security video which showed the evening ULP failed to complete the resident's evening cares and toileting scheduled at 9:00 p.m. The overnight ULP failed to complete safety checks and toileting scheduled at 1:00 a.m. and 5:00 a.m. The video showed no staff entered the resident's room from 8:00 p.m. until 6:00 a.m. and the overnight ULP entered the resident's room once for less than one minute.

The incident report indicated at 8:45 a.m., staff found the resident halfway out of his bed, with his head stuck between the side rail and mattress. Staff removed the bed rail and lowered the resident to the floor. It took four staff to assist the resident back to bed and administered pain medication for back pain. The facility added an additional toileting service at 3:00 a.m.

During investigative interviews, ULP stated the side rails were used to prevent the resident from falling out of bed. The resident had multiple falls trying to get out of bed to take himself to the bathroom. ULP stated the resident's services included safety checks.

During an interview, a nurse stated indicators that a resident is not appropriate to have side rails includes not being able to follow command and not demonstrate appropriate cognitive ability. The nurse stated the resident was independent with bed mobility.

During an interview, a supervising nurse stated the resident did not have consistent cognitive ability, had a history of falling while attempting to take himself to the bathroom, and took pain medication that would affect his cognition. The nurse stated the resident used the side rail when staff were assisting the resident with getting up. The nurse stated the resident did not have any other falls out of bed after she removed the side rail.

During an interview, a family member stated the facility emailed her to let her know side rails were placed on the resident's bed to stop him from falling out of bed. The family member stated she did not know there were any associated risks with the use of bed side rails.

The resident died several months later for health conditions related to his hospice enrollment.

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: Not Applicable.

Action taken by facility:
The facility removed the side rail.

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
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30434	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

(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: #HL304344835C /#HL304347908M On March 13, 2024, 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 88 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL304344835C /#HL304347908M, tag identification 1640,2310, 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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide evening cares, toileting assistance and safety checks as required for one of one residents reviewed. In addition, unlicensed personnel (ULP) falsely documented services were provided when camera review showed they did not. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01640		

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01640	Continued From page 2 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B's personnel file included a corrective action form dated August 18, 2023. The correction action form indicated on August 18, 2023 staff found [R1] with a fall injury. R1 was trying to get out of bed because his brief was "completely soaked." Security video review indicated ULP-B did not complete R1's evening cares as scheduled and only entered R1's room one time during the shift for less than a minute. ULP-F's personnel file included a corrective action form dated August 22, 2023. The corrective action form indicated ULP-F reported he entered R1's room at 9:30 p.m. and 6:00 a.m. to complete scheduled cares on August 17, 2023 [into August 18, 2023]. Security video review indicated no one entered R1's room from 8:00 p.m. to 6:00 a.m. (on August 17, 2023 into August 18, 2023.) R1's diagnosis included dementia and major depressive disorder. R1's service plan dated July 3, 2023, indicated R1 received behavior management services, medication administration assistance, and toileting assistance. R1's service delivery record dated August 2023, indicated R1 had scheduled evening cares at 9:00 p.m., scheduled CNA (certified nursing assistant) visit for the overnight and toileting assistance at 9:00 p.m., 1:00 a.m., and 5:00 a.m. On August 17, 2023, ULP-F falsely documented he provided evening cares at 9:00 p.m. and toileting at 9:00 p.m. On August 18, 2023, ULP-B	01640		

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01640	Continued From page 3 falsely documented she provided toileting services at 1:00 a.m. and the overnight scheduled CNA visit. The service delivery record indicated toileting services at 5:00 a.m. was not provided on August 18, 2023. During an interview on March 15, 2024, at 2:00 p.m., ULP-A stated R1 required safety checks and toileting assistance. ULP-A stated R1 would fall if he tried to get up on his own to go to the bathroom. During an interview on March 15, 2024, at 2:20 p.m., ULP-B stated R1 had multiple falls trying to take himself to the bathroom. ULP-B stated R1 required to be checked on rounds twice per shift. During an interview on March 18, 2024, at 3:00 p.m., registered nurse (RN)-D stated R1 had a number of falls. R1 lost his balancing trying to get up to the bathroom. RN-D stated staff were required to ass him getting up out of bed. RN-D stated R1 had scheduled safety checks. RN-D stated staff find the frequency of the safety checks on the resident's care plan and sign off on the service record. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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 service plan subject to accepted health care standards.	02310		

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02310	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to utilize a side rail as a mobility aide for one of one residents (R1) reviewed. R1 did not have the cognitive ability to use a side rail safely and unlicensed personnel (ULP) said it was used to prevent falls. R1 slid off his bed and had his head caught between the side rail and mattress. 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: R1's diagnosis included dementia and major depressive disorder. R1's service plan dated July 3, 2023, indicated R1 received behavior management services, medication administration assistance, and toileting assistance. R1's side rail assessment dated August 16, 2023, indicated R1 was unable to walk, had fluctuating consciousness, and alteration in safety awareness due to cognitive decline. The assessment indicated R1 was not using the side rail for positioning or support and had a history of falls. The side rail assessment indicated the right side rail was used and lacked side rail measurements required by the FDA (Food and Drug Administration).	02310		

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02310	Continued From page 5 R1's incident report dated August 18, 2023, indicated at 8:45 a.m., R1 was found half in and half out of his bed with his head between the mattress side rail. The side rail was removed and R1 was lowered to the floor. Four staff assisted R1 into bed. Hospice assessed R1 and provided medication for back pain. An additional toileting service was added for R1 at 5:00 a.m. R1's service delivery record dated August 2023, indicated the additional toileting service time added was at 3:00 a.m. on August 18, 2023. R1 had previous scheduled toileting times of 1:00 a.m. and 5:00 a.m. during the night shift. R1's progress noted dated August 18, 2023, incidated R1's side rail was removed and would remain off until hospice evaluated. During an interview on March 15, 2024, at 2:00 p.m., unlicensed personnel (ULP)-A stated R1 used the side rails so he would not fall out of bed. During an interview on March 15, 2024, at 2:20 p.m., ULP-B stated R1 used side rails on his bed to prevent R1 from falling out of bed. ULP-B stated R1 had multiple falls trying to take himself to the bathroom prior to the rails on his bed, and R1 continued to attempt to get out of bed once the side rails were in place on his bed. During an interview on March 18, 2024, at 2:00 p.m., registered nurse (RN)-C stated indicators that a resident is not appropriate to have side rails includes the resident not being able to follow command and not being able to demonstrate appropriate cognitive ability. RN-C stated the resident was ambulatory. During an interview on March 18, 2024, at 3:00	02310		

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02310	Continued From page 6 p.m., RN-D stated when assessing appropriateness for a resident to have side rails, they look at how active they are in bed, if they are cognitively intact, if they have behaviors, and if they can call for help. RN-D stated R1's cognition varied depending on if he had his pain medications. R1 was seemed almost non verbal after being medicated with dilaudid. The licensee policy titled, "Side Rails," dated January 18, 2023, indicated if a side rail is acting as a restraint, appropriate action should be taken. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. 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	No plan of correction is required for this tag.	