Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304929425M
Compliance #: HL304927163C

Date Concluded: May 14, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804
St. Louis County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 alleged perpetrator (AP), a facility staff member, neglected the resident when safety checks were not completed and the resident was found on the floor in his bathroom with wounds to his head, and legs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to complete two safety checks during the shift to ensure the resident was safe. The resident was found on the floor after approximately 12 hours and was admitted to the hospital with injuries. The resident passed away.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and the AP. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules,

and related facility policy and procedures. Also, the investigator observed current staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension and chronic kidney disease. The resident's service plan included safety checks three times a day at 8:00 a.m., noon, and 7:00 p.m. The resident was independent with transfers, walking, dressing, and bathing.

A facility incident report indicated one day the resident was found at 7:30 p.m. kneeling on the bathroom floor unable to call for help with wounds to his legs and open areas on both knees. The incident report indicated the resident thought he had fallen on the floor between 7:00 or 8:00 a.m. The resident was transported to the hospital via ambulance.

Hospital records indicated the resident's diagnoses included acute (severe) kidney failure because of rhabdomyolysis (breakdown of muscle due to injury, which if not treated immediately can lead to kidney damage), which occurred because of the fall and being on the floor for a prolonged period of time. The resident had swelling, open areas, and blisters to both his legs. The resident also had bruising and scraped open areas to his forehead. During the 10 days at the hospital, the resident's kidney function continued to worsen. The family chose comfort care and the resident transferred to a facility that specialized in hospice cares.

The resident death record indicated the resident's cause of death was acute kidney failure and traumatic rhabdomyolysis. The resident passed away 10 days after being discharged from the hospital.

During an interview, unlicensed personnel stated the resident was independent with cares, however, the resident had an evening safety check scheduled. The unlicensed personnel stated that evening she went to complete the resident's safety check, knocked on the resident's apartment door however, the resident did not answer like he usually did. The unlicensed personnel let herself into the resident's room, and upon entering, found the resident in a kneeling position leaning forward on the bathroom floor with no clothes on. The resident stated he had fallen getting out of the shower at approximately 8:00 a.m. The unlicensed personnel called for assistance and remained the resident, while trying to keep him awake. The resident had sores on his legs. Emergency services came and took the resident to the hospital.

During an interview, nursing leadership stated, the unlicensed personnel had an electronic tablet with the resident's plan care for review. The unlicensed personnel signed off when the resident services were completed. The day the resident fell, the resident had three scheduled safety checks. Leadership stated through the facility investigation, it was determined two of the resident's safety checks were not completed by the AP.

During an interview, the AP stated she was responsible for checking on the resident the day he had fallen. The AP stated the resident was independent with cares but needed two safety

checks on her shift. The AP provided no additional pertinent information on the lack of completing safety checks on the resident.

During an interview, the resident's family member stated the resident was independent with cares and had three safety checks schedule to ensure the resident was okay. After his fall, the resident passed away 20 days later.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Resident was transported to the hospital and the AP was placed on leave during investigation. The facility initiated additional resident checks at mealtimes. 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
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30492	A. BUILDING: _____ B. WING _____	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN DULUTH THE SHORES	4000 LONDON ROAD DULUTH, MN 55804

(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: #HL304929425M/#HL304927163C On April 22, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 63 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL304929425M/#HL304927163C, 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 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		