Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307022240M
Compliance #: HL307021203C

Date Concluded: July 29, 2024

Name, Address, and County of Licensee Investigated:
Three Links Health Services
815 Forest Avenue
Northfield, MN, 55057
Rice County

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

Evaluator's Name: Danyell Eccleston, RN, 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) neglected the resident when the AP left chemical cleaner unsecured in the kitchen. The resident drank some of the cleaner and was transferred to the hospital via emergency services.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP left cleaning chemicals out in the kitchen in the memory care unit. The resident drank some of the chemical, experienced pain and burning in his mouth and throat, and was sent to the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff providing care and interacting with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with cognitive support and safety checks and the resident's assessment indicated the resident was forgetful, confused, and had impaired decision-making. The assessment also indicated the resident slept on and off throughout the day and night.

Resident progress notes indicated the resident saw a jug on the counter and thought it was water and poured some out and drank the contents. The AP returned from mopping the bathroom and saw the resident with a look of pain and disgust on his face. The resident indicated he drank contents from the jug containing chemicals because, "… it was dark and I wanted water, but the fridge was locked and that looked like a pitcher of water, so I poured it out in my mug and took a sip. After that I spit it out because it was bad." The AP contacted staff and the manager on call regarding the incident. Emergency services was contacted, and the resident went to the emergency department. The resident returned from the facility later that morning and reported mouth pain when eating a few bites of food.

The AP's employee file indicated the facility educated the AP regarding use of chemicals for housekeeping tasks**.**

Observation of facility revealed locked storage under the kitchen sink for chemicals and door code entry to the laundry room where other chemicals are stored.

During interview, a leadership staff stated staff were directed to keep cleaning chemicals in a secured area when they were not using them.

During interview, an unlicensed staff stated staff utilize chemicals for cleaning duties and are taught to keep chemicals secured. The unlicensed staff stated cleaning chemicals, including dish soap, are not to be left out because a resident could think chemicals are something to drink.

During interview, the AP stated the facility provided education about keeping cleaning chemical secure. The AP stated she worked the night shift when most of the cleaning was conducted and obtained sanitizer from the laundry room to clean. The AP thought all of the residents were asleep and left the sanitizer on the kitchen counter and then proceeded to clean the bathroom floor. The AP heard commotion and went to the kitchen and saw the resident spitting in the sink. The AP questioned the resident and the resident stated he drank some of the cleaner that was on the kitchen counter because he thought it was water. The resident indicated he was experiencing burning and pain in his mouth and the AP contacted a staff member for support and called emergency services.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Internal review of incident conducted and re-education of staff.

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
Rice County Attorney
Northfield City Attorney
Northfield Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30702	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS HEALTH SERVICES	809 FOREST AVENUE NORTHFIELD, MN 55057

(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: #HL307021203C/#HL307022240M On May 30, 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 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307021203C/#HL307022240M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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 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	No plan of correction is required for this tag.	