Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307587988M
Compliance #: HL307584985CC

Date Concluded: April 29, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Seasons of Apple Valley
15359 Founders Lane
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Christine Bluhm, 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:
The alleged perpetrator (AP) neglected the resident when she did not complete assigned tasks for the resident that included safety checks, repositioning and administering comfort medications as ordered. The AP documented she completed the tasks in the resident's record. The resident was found deceased the next morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP, who was an unlicensed caregiver, did not completed the scheduled services on the overnight shift and falsely documented in the resident's record she had completed them. The AP also did not give the resident, who was receiving comfort cares, her scheduled medications because they had not been entered as a service task for the resident assistants.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident medical record, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions and services with residents during a visit to the facility.

The resident resided in an assisted living facility and received hospice services. The resident's diagnoses included stage four breast cancer with metastasis to the lung. The resident's most recent assessment indicated the resident required assistance with all activities of daily living which included toileting, repositioning, meal set up, safety checks and medication administration.

The facility's internal investigation indicated the resident did not receive her scheduled pain medications the night before she passed away. The same document indicated the AP, who worked that night shift, did not enter the resident's room but did document services such as repositioning and toileting as completed. The AP said the resident typically put on her call light if she needed assistance in the past, so the AP did not enter the resident's room.

A few days before this night shift the facility updated the resident's care plan to a health decline and the resident was to receive all cares in bed. The resident's updated service plan included scheduled incontinence care and repositioning assistance during the overnight hours.

The day before this night shift the resident's progress notes indicated the resident had an adjustment in pain medication, which included scheduled medications overnight, because of increased pain as recommended by hospice.

The medication administration (MAR) indicated the medical provider ordered a medication for pain and/or shortness of breath and an additional medication for anxiety, which were scheduled overnight at 12 am and 4 am.

A review of the MAR indicated the AP administered neither medication at 12 am and 4 am on that night shift.

The following morning, the progress notes indicated the resident was found deceased.

Review of email correspondence from the facility to the hospice team indicated hospice did not enter the new medications in the way where it would have triggered the night staff to open the medication record. The email indicated overnight staff typically did not give medications and might not review the MAR.

The resident's service delivery record indicated the AP documented she completed the scheduled services during the overnight hours which included toileting at 12 am, 3 am, 5:30 am, a risk fall check at 1 am, and repositioning checks at 1:30 am and 4:30 am.

During interview with the investigator, the AP stated she did not know the resident was on hospice or in a critical condition. She stated there was not anything that indicated this or there was a new medication order scheduled. The AP stated she did not enter the resident's room that night because in the past, the resident had told her she was use the call light if she needed anything and she would be woken up and not be able to fall back to sleep.

During an interview, a manager stated that when the AP was interviewed, the AP admitted she falsely documented she had completed the scheduled services. The manager stated it is not known when exactly the resident passed away or if she would have benefited from pain medication because the AP did not enter the room at all on the overnight shift.

During interview, a trainer who provided staff education stated staff members are provided iPads every shift, which lists the residents' scheduled services The trainer stated it is the responsibility of the caregivers to review and complete the services each shift.

During an interview, an unlicensed caregiver who worked the day prior to the resident's passing, stated she reported to the evening shift to watch for new comfort care medication orders. The staff member stated that she did not know if the evening shift verbally passed on to the AP (overnight shift) of the resident's condition, but it is all the caregivers' responsibility to review the communication book for resident updates as well as to follow and complete the scheduled services on the iPad.

During interview, a family member stated family had been with the resident most of the time to ensure she was repositioned and received her pain medication. Hospice and the family member spent a couple of hours setting up a pain medication schedule for facility staff to administer so family could go home and get some rest during the night. They were assured someone would reposition her and contact them if there were any changes. When the family member woke up that morning, she thought it must have well because she had not heard anything. When she arrived at the facility, the resident was found deceased and in the same position she had been that night when she left the evening before.

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:
The facility investigated the incident. The AP no longer works at 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
Dakota County Attorney
Apple Valley City Attorney
Apple Valley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30758	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

(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, sectio144G.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: HL307584985C/#HL307587988M On March 28, 2024 the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. The following correction order is issued/orders are issued for #HL307584985C/#HL307587988M 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	

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0 000	Continued From page 1	0 000	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, 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 Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		