Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307684863M
Compliance #: HL307688213C

Date Concluded: July 24, 2023

Name, Address, and County of Licensee Investigated:
Ecumen Sand Prairie
700 Knight Street
St. Peter, MN 56082
Nicollet County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 neglected the resident by failing to report and follow-up after the resident fell, which eventually resulted in compartment syndrome (a painful condition when pressure within muscles builds to dangerous levels).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the unlicensed caregiver #1 failed to report the resident's unwitnessed fall immediately, both the facility nurse and the resident's nurse practitioner were informed and assessed the resident in the next two-to-three days. Unfortunately, two weeks later, the resident developed compartment syndrome and a deep vein thrombosis (blood clot) which required hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures, incident reports, and

the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living. The resident’s diagnoses include osteoarthritis, schizophrenia, and hypertension. The resident’s service plan included assistance of one person with all activities of daily living. The resident’s assessment indicated she needed assistant of one person with transfers and mobility.

The incident report indicated the resident was found on the floor one evening after an unwitnessed fall. The same document indicated she had pain and bruising at that time.

The facility’s internal investigation indicated the unlicensed caregiver who found the resident did not report the fall immediately, however a co-worker reported it on his behalf and asked the nurse to see the resident.

Two days after the fall the resident’s medical record indicated the nurse practitioner saw the resident, who reported the fall and complained of right shoulder pain. The nurse practitioner prescribed ice/heat treatment to the area for 20 minutes three times a day.

The resident’s progress notes indicated the nurse assessed the resident three days after the fall and observed dark purple bruising on her right arm but observed full range of motion with minimal swelling and no tenderness. The same document indicated the nurse saw the resident four more times over the next two weeks in which the resident’s symptoms were stable and seemed to be slowly resolving. However, one night the resident reported an increase pain in her right arm and shoulder and so she was sent to the emergency room.

The emergency room documents indicated the resident had bruising with compartment syndrome and a deep vein thrombosis in the arm, which required emergency surgery.

During an interview, unlicensed caregiver #1 stated he found the resident on the floor in her apartment. After assisting the resident back to bed using a gait belt, he said the resident claimed to be fine and uninjured. However, he did not notify the nurse or the family, though he did inform his co-worker.

During an interview, unlicensed caregiver #2 stated she became aware of the incident the following day, promptly filled out an incident report, and notified both the nurse and a family member. The resident complained of pain, and pain medication was administered to provide relief. The nurse frequently assessed the resident, recommending the use of ice packs to reduce swelling and alleviate pain.

During an interview, the family member confirmed the resident fell in her recliner, and a staff member assisted her in getting up. The facility informed the family member about the incident two days later. Initially, there seemed to be some improvement, but later the arm's swelling

became more pronounced, and it was discovered that the resident had a blood clot. Regrettably, the resident lost movement in her arm and was unable to regain strength. Throughout the two weeks following the incident, the nurse provided updates, frequently assessed the injury, and closely monitored the resident's condition per family member.

During an interview, the nurse stated that she began working at the facility three days after the incident occurred. She became aware of the incident through unlicensed caregiver #2. She stated she promptly assessed the resident and continued to do so every three days until the resident's transfer to the hospital. Unlicensed caregiver #1 received corrective action and the facility provided education to all the staff members regarding reporting falls.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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, due to memory loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Corrective action for unlicensed caregiver #1 and facility-wide education on reporting falls

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
	30768	A. BUILDING: _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SAND PRAIRIE	700 KNIGHT STREET SAINT PETER, MN 56082

(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 June 26, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL307684863M/HL307688213C . No correction orders are issued.	0 000		