Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307851900M
Compliance #: HL307859612C

Date Concluded: August 1, 2024

Name, Address, and County of Licensee Investigated:
Ecumen Prairie Hill
1305 Marshall Street
St. Peter, MN 56082
Nicollet County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Not Substantiated

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 neglected the resident when the facility failed to provide supervision and medical care to the resident after the resident fell and lodged an arm between her mattress and a side rail attached to her bed. The resident was found unresponsive and sent to the hospital where she later died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility staff followed the resident's plan of care and called for emergency medical care when the staff found the resident. The resident was independent and required minimal services. The resident had the pendant call button attached to her but never pressed the button to call for help. Staff found stool on the bathroom floor, which was unusual because the resident had been continent. It was likely the resident suffered from an unforeseen medical event that prevented her from pressing her call pendant.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical records, death record, hospital records, facility internal investigation, facility incident report, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator toured the facility and observed resident safety checks, medication administration, and a meal.

The resident resided in an assisted living facility The resident's diagnoses included a recent urinary tract infection, fainting, and cardiac pacemaker. The resident's service plan included safety checks once per day, assistance with bathing, and two meals per day. The resident was independent with walking with her walker, using the bathroom and able to use her call pendant to make her needs known.

According to the internal investigation, unlicensed personnel (ULP)-2 found the resident on her apartment floor with one arm lodged between the mattress and her approved siderail. The resident was breathing but unresponsive. Staff called emergency services and the resident went to the hospital. The resident's only scheduled service that day was a safety check scheduled at 9:00 a.m. Unlicensed personnel (ULP)-1 observed the resident in the hallway around 8:00 a.m. Per dining staff, the resident does not come to the dining room for breakfast; she usually attended lunch and dinner. ULP-2 checked on the resident after she failed to attend dinner and found her on the floor next to her bed. The hospital staff initiated life saving measures but were unsuccessful.

During an interview, a nurse said the ULP checked on the resident after failing to attend supper. Staff reported the resident's pendant light was attached to her, but the resident never called for help. The resident's services included two meals per day, lunch and supper, assistance with bathing once weekly, and one safety check at 9:00 a.m., hence why the 9:00 a.m. safety check was her only scheduled service that day.

During an interview, ULP-1 said she saw the resident outside her apartment door around 8:00 a.m. She said the only service the resident received that day was a 9:00 a.m. safety check. That was only time ULP-1 observed the resident.

During an interview, ULP-2 said after the resident failed to attend supper, she checked on her and found the resident laying on the floor with her arm wedged between the mattress and the floor. They called emergency medical assistance immediately. She said the resident was breathing at the time but was unresponsive.

According to the resident's pendant push log, the resident's pendant light was not activated on the day of the incident.

According to the hospital record, the facility staff found the resident on the floor, unresponsive. She had a heartbeat and was breathing. Her arm was lodged between the bed and siderail. The resident was incontinent of stool. Staff reported seeing stool on the bathroom floor in her apartment. The resident was in respiratory failure upon hospital arrival and went into cardiac arrest. Life saving measures were unsuccessful.

According to the resident's death record, the resident died of natural causes.

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, deceased.
Family/Responsible Party interviewed: No, family member never returned interview request.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation and provided education to all staff. The facility implemented a protocol for dining room staff to alert nursing staff when a resident does not attend a meal.

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
	30785	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN PRAIRIE HILL	1305 MARSHALL 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 July 18, 2024, the Minnesota Department of Health initiated an investigation of complaint HL307859612C/ HL307851900M, HL307854227C/ HL307853781M. No correction orders are issued.	0 000		