DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307978287M
Compliance #: HL307975474C

Date Concluded: April 3, 2024

Name, Address, and County of Licensee Investigated:
Watkins Manor
175 East Wabasha Street
Winona MN, 55987
Winona County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility and 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 facility neglected a resident when they manipulated her into receiving hospice care, stopped her mental health medications, then overmedicated her. As a result, the resident fell, sustained a head injury, and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. The resident appropriately admitted to hospice services for kidney failure and heart failure. The resident had signs of approaching death when the AP, a registered nurse, failed to use her professional judgement and act in the resident's best interest when she directed the licensed practical nurse (LPN) and unlicensed personnel (ULP) to transfer the resident out of bed and placed her into a wheelchair. All three staff left the unconscious resident unattended. The resident fell, sustained facial injuries, went to the hospital, and died of blunt force trauma.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice staff. The investigation included review of resident records, employee records, hospital reports, and death record. Also, the investigator toured the facility and observed the medication administration system.

The Hospice Foundation of America webpage titled, Signs of Approaching Death, indicated changes in health status with approaching death can include coughing or noisy breaths from secretions when unable to swallow, consciousness changes to unresponsiveness, periods of agitation and restlessness, and skin changes to purplish, pale, grey, or mottled.

The resident resided in an assisted living facility. The resident's diagnoses included blindness, bipolar disorder (mood changes), diabetes, anxiety, depression, heart failure, renal (kidney) disease, and atrial fibrillation (irregular heart rate). The resident's service plan included assistance with medication administration, diabetic and anticoagulation (blood thinning) monitoring, dressing, showering, and toileting. The resident's nursing assessment indicated she was anxious, but alert and orientated to herself and her surroundings. The resident walked but also used a wheelchair. The nursing assessment indicated her health was declining. The resident's progress notes indicated she experienced increasing weakness, falls and health concerns with infections and abnormal lab work indicating kidney failure.

The facility's Uniform Disclosure of Assisted Living Services and Amenities indicated the facility did not provide transfer assistance with mechanical lifts.

Facility records indicated the resident's care needs increased beyond what they could provide. The facility started the process for terminating her services and attempted to find alternate placement for her. The records indicated the resident became more dependent upon others for all her daily care needs, including her mobility status. The resident was inconsistent when she transferred, and she was a safety risk to herself because of it. She required one staff member to stay with her frequently, which the facility was unable to provided. The resident's new behavior included calling out for help frequently, even when caregivers were present. The facility was unsuccessful in finding alternative placement, so the resident continued to live at the facility.

During an interview, a manger said the resident required a safer environment, and more care than the facility could provide. The manager said the resident's family limited their options for placement of the resident. Throughout the process, the resident's health continued to decline. The resident's kidney function deteriorated, and she required dialysis (process in which a machine removes excess fluid and waste from the blood). The resident requested hospice cares. The family did not support her decision, so the facility contacted an ombudsman (advocate) to talk with the resident who discussed the decision with her. The manager said the facility gave the resident and family options for hospice agencies and the family chose a hospice agency.

The resident admitted to hospice services approximately 10 weeks after continuous health and functional status decline due to kidney failure and heart failure. The resident's medication administration record indicated she received medications in accordance with her physician's orders and appropriately as she began to have signs of approaching death.

The resident's progress notes indicated the first day of hospice, the resident was unable to grasp a mechanical lift stand to participate consistently with transfers. Over five days, the resident decreased consciousness to sleepy and short periods of wake time. The resident had periods of restlessness and calling out. The resident was unable to swallow to take oral medications or food. The resident had pursed lip breathing and required oxygen. The day before the fall, the resident was sleepy, weak, and had limited ability to stand with a mechanical lift with three staff members assisting. The hospice nurse reviewed medications.

The morning of the fall, the resident's progress note indicated the resident was unable to swallow medications or liquids. The resident's voice was quiet, her skin was pale, and lips were dusky. The resident had gurgling, and staff contacted hospice.

A hospice communication noted indicated the hospice nurse saw her approximately three hours prior to the fall. The hospice nurse assessed the resident due to a change in her condition. The resident was minimally responsive and stared at the ceiling. The resident's skin was dry and pale. The resident had stomach pain when touched. The hospice nurse directed facility staff to administer pain and anxiety medication and indicated the resident was "transitional" (beginning the final stages of dying).

Fall event documentation indicated a staff member went to check on the resident and found her lying on the floor, face down, with blood under her head. The documentation indicated the resident was alert and calling out for help. Facility staff called 911 and they transported the resident to the hospital.

Hospital records indicated the resident required sutures to a facial laceration. The resident was unresponsive from the time she arrived at the hospital until her death the following day.

The resident's death record indicated immediate cause of death was blunt force injuries of the head due to fall.

During an interview, the LPN said the resident's family wanted the resident to get out of bed. She told the family members she did not think it was a good idea and wanted the resident to be comfortable. The LPN said the resident remained in bed for the shift prior to hers and she was uncomfortable getting her up. The LPN did not want to make the decision to get her up because the resident was weak, and more difficult to transfer. She deferred the decision to the AP, who was in charge. The LPN said herself, the AP and the ULP placed the resident into the mechanical stand lift and transferred her into a wheelchair. The LPN said the resident was not strong and could not hold onto the machine, however, there was a belt around her to hold her up. The LPN

said the resident was restless in bed, but she was unsure if the restlessness stopped once the resident sat in the wheelchair. The LPN said she, the AP, the ULP left the room after the transfer. The ULP saw the resident's family in the nursing office and went back to check on the resident when she found her laying on the floor.

During an interview, the ULP said the day before the fall on the shift she worked the resident was in bed all day and they were repositioning her every couple of hours because she was comfortable in bed. The ULP said the evening of the fall, family were adamant and persistent about getting her up into the wheelchair. The ULP said the LPN said she was not comfortable getting the resident up unless the AP was there to help. The ULP said the resident was still drowsy and did not participate in the transfer because she was weak. The ULP said they left the resident sitting in her wheelchair with family. The ULP said she fell hours after the transfer and could not recall what time. The ULP said she saw family talking to the AP, so she went to check on the resident when she found her on the floor.

During an interview, the AP said the resident's family members were adamant the staff put the resident into a wheelchair. The AP said the family was angry and told her they were in charge of the resident. The AP said the family would not take "no" for an answer. The AP told family it was safer for the resident to stay in bed because she was unable to walk. The AP said she received assistance from the LPN and ULP, and they used a mechanical stand lift to get the resident out of her bed and put her into a wheelchair. The AP said after the resident transferred into the wheelchair, the family members wanted to talk with her. The AP and the family left the resident and went into her office. While they were there, they heard the resident holler for help and went into her room. The AP said the resident fell to the floor, on her face, and there was blood around her.

During an interview, a family member said the resident was "drugged" and could not stay up. The resident could barely talk and could not keep her eyes open. He wanted to take her for a walk, but she could not stand up. The family member said a nurse told him the resident was dying and he needed to tell her, "Goodbye", and let her go. The family member said he left the facility but returned. The family member said when the resident sat in the wheelchair she was, "out of it." The resident had her held tilted back and was sleeping.

During an interview, a manger said she was not present in the facility at the time of the incident. The manager said they reviewed the incident but made no further changes because the resident did not return to the facility.

During a follow up interview, the AP said, in hindsight, she should have been firmer with the resident's family when they wanted her up. The AP said she should have told them, "No".

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility sent the resident to the hospital after the fall.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Winona County Attorney
Winona City Attorney
Winona Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30797	A. BUILDING: _____ B. WING _____	R-C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATKINS MANOR	**175 EAST WABASHA STREET WINONA, MN 55987**

(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 May 13, 2024, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for complaint #HL307975474C/#HL307978287M. Watkins Manor was found to be in substantial compliance with state regulations.	{0 000}		
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).	{0 620}		

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{0 620}	Continued From page 1 (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No action required.	{0 620}	No further action required.	