Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308316747M **Date Concluded:** October 10, 2023

Compliance #: HL308312716C

Name, Address, and County of Licensee Investigated:
Westwood of Duluth
925 Kenwood Avenue
Duluth, MN 55811
St. Louis County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility 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 failed to perform safety checks to ensure the resident was present in the facility. The resident left the facility one night to go for a walk but never returned. The facility did not discover the resident was missing until 24 hours later when unlicensed personnel (ULP) noticed the resident did not show up for the evening meal. The resident endured unnecessary pain and suffering from being outside over 30 hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Several facility staff failed to perform the resident's required safety checks and medication reminders which prolonged the time the resident was outside in the elements and the facility's opportunity to take immediate action to locate the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed a family member. The investigation included review of the resident's facility, hospital, and clinic records. The investigator reviewed the facility's internal investigation report, facility's policies and procedures, and employee files. The resident's law enforcement report was reviewed. Also, the investigator observed resident cares and interactions with facility staff during her onsite investigation. The resident enjoyed walking the facility grounds.

The resident resided in an assisted living facility. The resident's diagnoses included late onset Alzheimer's disease. The resident's service plan indicated the resident received three "I'm okay" (safety checks) at 10:00 a.m., 2:00 p.m., and 5:00 p.m., and two medication reminders at 11:00 a.m., and 10:30 p.m. The resident's assessment indicated the resident was not oriented to person, place, or time and had impaired judgement or decreased safety awareness due to her Alzheimer's diagnosis.

The facility's internal investigation report indicated one evening at 7:30 p.m., an ULP alerted a facility nurse the resident did not attend the evening meal. Review of the facility's video surveillance footage indicated the resident was last seen exiting the facility's front door the previous day at 5:59 p.m., to walk facility grounds. Facility staff, county search and rescue, and law enforcement searched inside and outside campus buildings and grounds. The resident was found wet and muddy, lying in a swampy, marshland behind a campus building. The resident was dehydrated and had abrasions to her tailbone and elbows. The resident showed signs of hypothermia (low core body temperature) and rhabdomyolysis (muscle tissue breakdown) from having spent over 30 hours outside. The resident was visibly upset and tearful and was unable to recall the events. Emergency medical services (EMS) transported the resident to a local hospital.

The resident's hospital record indicated the resident had no detectable temperature upon arrival due to prolonged exposure to the outdoor elements. The resident's core body temperature was 28 degrees Celsius (C), (normal: 36C-38C), signifying severe hypothermia. The resident was oriented to self only, and was confused, agitated, and unable to answer questions. The resident was diagnosed as critically ill with evidence of multi-organ dysfunction. The resident spent several days in the hospital's intensive care unit (ICU) and neurological unit.

The resident's facility record lacked documentation the resident received her required evening safety check or medication reminder the night the resident left the facility. In addition, an ULP inaccurately documented she performed the resident's medication reminder and safety checks during the time the resident was missing.

During an interview, an ULP stated prior to the incident, the process for performing safety checks remained unchanged for the past few years. The ULP stated safety checks during mealtimes consisted of looking to see which residents were not in the dining room. The ULP stated facility protocol was to perform safety checks on residents not in the dining room and

enter their apartments, in addition to checking the resident sign-out books located on each floor and at the front desk. The ULP stated next, family members were called to see if the resident was with them. The ULP stated the last step was to contact the nurse manager for further instruction if the resident was still not located.

During an interview, administrative staff stated the facility marketed and offered three daily safety checks for its assisted living residents which entailed physically laying eyes on the resident. Administrative staff person stated the ULP's were required to perform a safety/wellness check on the resident if they did not see a resident who typically ate meals in the dining room. Administrative staff stated the ULP's were required to document when a safety check was not completed. Administrative staff stated during the facility's internal investigation, an ULP stated she accidentally clicked the medication reminder as completed instead of not completed. Administrative staff stated there was a communication breakdown between the ULP's who worked the shifts, stating some shifts overlapped by 30 minutes which gave ample time for staff to perform a hand-off report and perform checks. Administrative staff stated facility staff were good employees who learned from this unfortunate situation.

During an interview, the facility nurse stated the facility set-up safety checks to be done at mealtimes, stating it was a way to visually lay eyes on multiple residents. The nurse stated residents still received a safety check even if they were not in the dining room. The nurse stated it is the facility's protocol to ensure the ULP's "lay eyes" on a resident when they perform safety checks. The nurse stated the ULP's are supposed to check the sign out books located on each floor and at the main entrance if they do not visually see a resident, stating "it's in their service plans." The nurse stated there was a breakdown in staff duties and responsibilities during the time the resident went missing, stating the resident should have been found the first night, not the second.

During an interview, a family member stated she received a phone call from the facility the night the facility became aware the resident was missing, asking her if the resident was at her home. The family member stated several hours later, the facility nurse called and said they found the resident outside. The family member stated she was confused when the nurse stated the resident was "still alive," stating she was under the impression the resident had been missing a few hours, not 30 hours. The family member stated the resident's physical and cognitive status drastically declined after the incident, stating the resident never returned to her baseline.

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 passed away two weeks before the onsite investigation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reeducated staff on accurate documentation and wellness (safety) checks.

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.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30831	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

(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: #HL308312716C/#HL308316747M On August 24, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 56 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL308312716C/#HL308316747M, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30831	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

(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
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 the facility 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.	