

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308391061M
Compliance #: HL308398387C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee

Investigated:

St. Mark's Memory Care
400 15th Ave SW
Austin, MN 55912
Mower County

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

Evaluator's Name: Deb Schillinger 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 staff neglected the resident when pain was not reported to nursing or hospice.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility unlicensed caregiver reported the resident did not have complaints of pain throughout the night and services were provided as directed by the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice staff members and family members. The investigation included review of the resident record, death record, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator toured the facility and observed facility staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and repeated falls. The resident's service plan included assistance with medication management, toileting, and safety checks. The resident's assessment indicated the resident required physical assistance of one caregiver to transfer to wheelchair for mobility. The resident was receiving hospice care.

One morning a concern arose that the resident was not provided adequate pain control or care by the facility overnight as the resident was said to be heard yelling in pain as a hospice team member approached the resident's room to provide cares.

The previous day around 12 noon the resident had a fall. The subsequent facility incident report indicated the resident sustained a head injury with skin tears from the fall. The same incident report indicated the resident's medical provider was notified as well as the hospice provider.

Following the fall, the medical record indicated the resident required as needed (PRN) pain medication three times after the fall to manage pain as provided by the hospice team that afternoon and into the evening. A review of the medical record identified no new orders were given by hospice regarding managing pain.

A review of the medical record did not identify PRN pain medications were not give overnight nor the following morning. The same review indicated the resident received PRN pain medications mid-afternoon.

The medical provider orders indicated the resident had PRN medication changes made but not until mid-afternoon of the day after the fall.

During an interview, the hospice team member stated she notified the hospice nurse of her observations and then provided cares to the resident. The hospice team member stated the resident did not yell while she provided cares. She stated Emergency Medical Services (EMS) came but they team arrived the resident was not yelling out in pain. The hospice team member stated she left the building before the hospice nurse arrived at the facility and the resident was not calling out in pain when she left.

During an interview, the unlicensed caregiver stated she was confused as she thought hospice staff was telling her to call 911. The unlicensed caregiver called nurse #1 who relayed to her, hospice was responsible for managing the care of the resident and to follow the hospice team's orders regarding care. The unlicensed caregiver stated the resident had not complained of pain throughout the overnight shift, nor did she hear the resident yelling out in pain at the time of the hospice team member's visit that morning.

The residents service check-off list in the medical record indicated cares were provided four times during the overnight shift, the last an hour prior to the hospice team member reported time of visit.

During an interview, nurse #2 stated when she arrived the morning of the incident the resident was not yelling out in pain. Nurse #2 completed an assessment on the resident, and the resident was able to respond by stating she was comfortable when questioned by the nurse. Nurse #2 reported she had no concerns regarding the cares the resident received during the night, the unlicensed caregiver followed care plan, and notified nursing staff appropriately.

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.

Insert maltreatment definition here.

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 is deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable the

Action taken by facility:

Assessed the resident for pain and provided PRN medications as needed.

Action taken by the Minnesota Department of Health:

No further action at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30839	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/22/2024
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NAME OF PROVIDER OR SUPPLIER ST MARK'S HERITAGE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SW AUSTIN, MN 55912
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(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	<p>Initial Comments</p> <p>On May 22, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL308398387C/#HL308391061M.</p> <p>No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____