*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL312143060M
**Compliance #:** HL312142987C

**Date Concluded:** July 31, 2024

**Name, Address, and County of Licensee Investigated:**
Nagel Assisted Living
232 Elm Street South
Waconia, Minnesota 55387
Carver County

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

**Evaluator's Name:** Nicole Myslicki, RN
Special Investigator

**Finding:** Inconclusive

**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 resident committed suicide in his apartment.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The resident did not display signs of planning to commit suicide prior to the incident. The facility could not have known the resident would have committed suicide.

An alleged perpetrator (AP) was identified during the investigation. The Minnesota Department of Health determined neglect was inconclusive. It was unclear how much information the AP, a facility nurse, had regarding the resident's history of suicidal ideation, prior to the incident to have included care plan interventions and/or monitoring for behavioral changes.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the medical

examiner. The investigation included review of the resident record, death record, psychiatry records, facility internal investigation, facility incident reports, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed the resident's room and closet.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a brain injury. The resident's service plan included safety checks every hour and monitoring behavioral symptoms. The resident's behavior management plan indicated the resident had depression related to loss of independence and had lack of insight and denial of his health status. The resident's admission paperwork indicated the resident moved to the facility from out of state following an accident which caused his brain injury.

The facility's incident report indicated staff found the resident hanging from his closet with string around 3:50 p.m. Staff cut the string, got the resident down to the floor, and initiated cardiopulmonary resuscitation (CPR). The incident report indicated contributing factors included impaired mental status, impaired safety and judgement, and an unidentified mental health diagnosis. The incident report also indicated the resident did not have a history of suicidal ideation, no indication of any plans, and had recently been seen by psychiatry and his primary care provider.

A law enforcement report indicated deputies arrived at the facility after staff called 911, and the paramedics pronounced the resident deceased. Law enforcement investigated the scene and watched video footage which did not show anyone except the resident enter his apartment prior to the incident. During an interview completed by law enforcement, a staff member reported the resident had not been acting normal the couple of days leading up to the incident, including skipping meals and attending a community game (which he normally did not do). This staff member also stated the resident had made suicidal remarks in reference to other residents agitating him. The report also included an interview with the resident's family member. The family member stated the resident made suicidal comments about three to four months prior to the incident when he stated he wished he would have died during his accident. Family thought the resident had been moving in a positive direction and described the incident as very unexpected. The family member denied any self-harm attempts by the resident in the past.

The medical examiner's report identified the resident's cause of death as being attributed to ligature hanging and classified the death as suicide.

The resident's record included a psychiatric evaluation completed less than one week prior to the incident. During the evaluation, the resident denied depressive symptoms, anxiety, or worry. The evaluation identified the resident's judgement and insight as limited. The evaluation also identified the resident as psychiatrically stable and presented no immediate concerns. The evaluation included a plan to follow up in two months or sooner if needed, recommended following with psychotherapy, and no recommendations for medication changes. The evaluation also indicated no suicidal ideation was notes at the time of the assessment.

During an interview, unlicensed personnel (ULP)-1 stated facility staff checked on the resident every two hours. ULP-1 last saw the resident a few minutes before 2:00 p.m. in the dining room drinking coffee.

During an interview, ULP-2 stated she went around the unit to complete rounds and ensure each resident's safety towards the beginning of her shift. The resident had his door closed and did not like people in his apartment. ULP-2 completed another task, then went back to check on him. She opened the door enough to look into his apartment but did not see the resident in his bed as usual. ULP-2 opened the door completely and saw the resident sitting in a strange position in the closet. ULP-2 walked closer to the closet, then realized the resident had committed suicide. She ran to get help from the AP. Prior to this incident, ULP-2 had not been aware of the resident's history of suicidal ideation. Leading up to the incident, the resident seemed fine and continued to behave at his baseline. She did not see any signs of him wanting to hurt himself.

During an interview, multiple staff members stated they were not aware of the resident having a history of suicidal ideation and did not notice the resident behaving abnormally prior to the incident.

During an interview, the AP stated she felt shocked and did not see this coming. She stated ULP-2 came to get her for help and told her the resident killed himself. The AP found the resident hanging by what looked like a "hoodie" string, made into a rope. The AP initiated CPR and instructed another staff to check the resident's resuscitation status. When they saw the resident selected do not resuscitate (DNR) status, the staff stopped CPR. She cleared the room and closed the door while they waited for law enforcement and the medical examiner. The AP denied having prior knowledge of the resident's history of suicidal ideation. The AP stated he made comments like wishing they would have let him stay dead during conversations about not wanting to be at the facility but instead wanted to move back to his home state.

During an interview, a family member stated the resident had a history of threatening suicide, but he had not previously attempted to hurt himself. The family member stated she and other family members were shocked, and she never thought he would go through with committing suicide. After the resident's accident, he had not talked about suicide for over one year. One day, a few months prior to the incident, the AP told the family member the resident mentioned suicide. The family member told the AP the resident always talked about suicide but never attempted to hurt himself. Overall, the family member thought the facility had been professional and maintained communication with her regarding the resident and his mental health.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

**"Not Substantiated" means:**

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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. The resident is deceased.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
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
Midwest Medical Examiner’s Office

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 31214 | A. BUILDING: _____ B. WING _____ | C 06/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NAGEL ASSISTED LIVING | 232 ELM STREET SOUTH WACONIA, MN 55387 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL312149258C/#HL312141682M, #HL312142987C/#HL312143060M<br><br>On June 11, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 49 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction orders are issued for #HL312149258C/#HL312141682M, tag identification 1480, 2360.<br><br>No correction orders are issued for #HL312142987C/#HL312143060M. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 01480 SS=D | 144G.63 Subd. 3 Orientation to resident<br><br>Staff providing assisted living services must be | 01480 | | |

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| 01480 | Continued From page 1<br><br>oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to orient one of one unlicensed personnel (ULP)-E to one of one residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 admitted to the licensee September 11, 2023. R1's diagnoses included dementia. R1's service plan dated June 11, 2024, indicated R1 received assistance with behavioral interventions including redirection, leaving R1 alone if in a safe situation, and removing R1 from the upsetting environment. R1's assessment dated May 8, 2024, identified R1 as disoriented and confused, at risk for elopement, and a high fall risk.<br><br>ULP-E's staffing agency records indicated he received training on abuse and neglect and challenging behaviors in dementia on August 30, 2023.<br><br>The licensee-provided orientation binder, undated, included R1's face sheet, R1's provider orders for life sustaining treatment (POLST) and | 01480 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL | |

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| 01480 | Continued From page 2<br><br>blank orientation checklists. The orientation binder did not include R1's service plan, service delivery record, or other information informing agency staff how to provide individualized cares to R1.<br><br>The licensee's schedule indicated ULP-E worked in the memory care unit on January 23, 2024, from 2:00 p.m. to 10:30 p.m.<br><br>An incident report dated January 23, 2024, indicated at approximately 9:15 p.m., R1 became frustrated ULP-E blocked the memory care unit door and tried hitting him with his walker and with his hands. ULP-E tried grabbing R1's walker and hands. ULP-E then adopted a "fighter's pose," and as R1 began lowering his fists, ULP-E hit R1 in the face with his fist. R1 began swinging at ULP-E but lost his balance and fell backwards onto his buttocks. R1 sustained swelling and bruising to his hands.<br><br>During an interview on June 28, 2024, at 2:32 p.m., ULP-E stated he only received a general orientation but did not inform him what needed to be done with every individual resident. ULP-E stated he did not receive orientation to the licensee's policies and procedures, either. ULP-E stated as agency staff, he did not have access to the electronic health records to see what services the residents had and how to work with them. On January 23, 2024, another staff member asked him to monitor R1 while other residents were allowed out of the unit for a smoke. R1 became frustrated and started trying to hit ULP-E. ULP-E stated he inadvertently hit R1 while trying to deter R1 from hitting him.<br><br>The licensee-provided policy Orientation to Resident, undated, indicated the licensee would | 01480 | ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 01480 | Continued From page 3<br>orient each staff person responsible for providing assisted living services to that resident and to the specific services to be provided. This included individualized instructions about the resident.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01480 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person 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. | |