Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL315574942M
Compliance #: HL315576515C

Date Concluded: September 12, 2024

Name, Address, and County of Licensee Investigated:
Farmstead Care of Moorhead LP
3200 28th Street South
Moorhead, MN 56560
Clay County

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

Evaluator's Name: Brooke Anderson, 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 became lethargic and unresponsive and was hospitalized in the ICU with high Co2 (carbon dioxide) levels.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It was unable to be determined if the actions or inactions of facility staff contributed to the resident's change in respiratory condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, hospital records, personnel files, staff schedules, and related facility policies and procedures. At the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in assisted living memory care unit. The resident's diagnoses included muscular dystrophy and acute chronic respiratory failure. The resident's care plan included assistance with transfers and BiPAP (a non-invasive ventilator that helps people breathe by providing pressurized air into their airways) assistance. The resident's assessment indicated the resident had a history of respiratory acidosis (decreased ventilation resulting in high CO2 levels) and utilized oxygen and a BiPAP machine. The resident' assessment indicated for staff to apply the BiPAP at night and remove in the morning.

Complaint documents indicated the facility did not apply the resident's BiPAP resulting in two hospitalizations.

Review of the resident's record included a physician's order for the resident to wear a BiPAP while sleeping.

Facility documentation indicated the resident returned to the facility from a weekend outing with family. A family member told staff the resident was very tired and had slept in the vehicle on the way back to the facility. Facility staff transferred the resident to his bed with his oxygen on. The resident had two visitors after his return to the facility. A visiting physical therapist alerted a nurse that the resident was unresponsive. Family was notified, and the resident was sent to the emergency room. Facility documentation indicated the resident did not have his BiPAP on when found unresponsive and that he did not wear the BiPAP when he had visitors.

Hospital records indicated the resident was hospitalized for two days and discharged back to the facility with no new orders.

The day after the resident returned from the hospital, facility staff entered the resident's room in the morning and provided toileting assistance. The resident was alert at that time. One hour later, facility staff walked by the room and saw the resident sleeping in his wheelchair. A facility nurse was notified, the resident was assessed, and he was sent to the emergency room.

Hospital records indicated that prior to the incident, the resident was ordered a BiPAP for nighttime use and a ventilator (a machine that helps people breathe when they are unable to do so on their own) during the daytime hours. Hospital records indicated the resident had not used the ventilator since moving into the facility because the resident was more comfortable with the BiPAP machine. The records indicated the hospital admissions may have been due to progression of the resident's neuromuscular disease. The physician discontinued the BiPAP and ordered that the resident use the previously ordered ventilator.

During an interview, facility nurse #1 stated that prior to the first incident when the resident returned from the weekend outing, a family member called and requested for an assessment to be completed on the resident. The resident's vital signs were stable, and the family member informed staff that the resident was tired and instructed facility staff to let him rest. Facility nurse #1 asked staff to put the resident in his bed. A while later, a physical therapist reported

that the resident was unresponsive. Facility nurse #1 assessed the resident, the family member was notified, and the resident was sent to the emergency room.

During an interview, a facility staff member stated that the night of the second incident the resident was up watching a movie and declined to go to bed when asked. The resident was alert and able to communicate his needs to staff. The staff member described the night of the incident as a normal night and indicated that the resident usually stayed up late.

During an interview, facility nurse #2 recalled that prior to the first incident the resident returned to the facility lethargic after an outing with family. Staff assisted him to bed with his oxygen, but the BiPAP was not turned on because the order was for him to have it on at night. The nurse stated at the time of the second incident staff offered to put the resident to bed but he refused. Staff reported the resident was lethargic, his family was notified, and he was sent to the emergency room. The nurse stated she believed the resident's respiratory status changed due to a decline in his disease process.

During an interview, the resident's family stated the resident should have had his BiPAP on when he was laid down and when he was sleeping in his wheelchair. After the second hospitalization, the BiPAP was discontinued, and the resident was placed on a ventilator because his lung condition had declined. The family member stated the resident planned to move out of the facility.

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

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed assessments, obtained vitals, and sent the resident to the emergency room when a change in condition occurred.

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
	31557	A. BUILDING: _____ B. WING _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMSTEAD CARE OF MOORHEAD LP	3200 28TH STREET SOUTH MOORHEAD, MN 56560

(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 August 7, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL315576515C /#HL315574942M . No correction orders are issued.	0 000		