Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317614446M
Compliance #: HL317617575C

Date Concluded: September 25, 2023

Name, Address, and County of Licensee Investigated:
Lino Lakes Gracewood
675 Market Place Drive
Lino Lakes MN, 55014
Anoka County

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

Evaluator's Name: Kris Detsch, 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 a resident when they failed to provide medical assistance to the resident which resulted in his death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although there was a delay in contacting emergency medical services (911), it cannot be determined whether emergency medical services were necessary to maintain the resident's health because his health was declining, and he did not want to have cardiopulmonary resuscitation (CPR) performed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, employee files, law enforcement records. Also, the investigator toured the facility and observed staff interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease, dementia, hallucinations, and frequent falls. The resident's service plan included assistance with bathing, dressing, grooming, meals, behavior management, housekeeping, laundry, and medications. The resident required safety checks and sleep monitoring. The resident's nursing assessment indicated he had severe memory loss, and his health status was declining.

The resident's progress notes indicated his physical and mental health were declining one month prior to his death. In addition, physicians, physical therapist, and occupational therapist evaluated the resident because of his health decline. The resident's physicians changed his medications and nursing staff continued to monitor the effects of the changes, however the resident continued to decline during the month. Five days prior to his death, the resident fell, sustained left arm pain and facial swelling around his eye. Two hours later staff observed the resident to be "shaking" and his skin color appeared "jaundice" (yellow). Facility staff sent the resident to the hospital, and he remained there until his return to the facility the day before his death. Upon his return to the facility, nursing staff indicated he "severely declined", and spoke to his family about starting hospice cares. Nursing staff informed the resident's primary care provider of his declining health status and she indicated she would contact the resident's family the following day. Later in the night, nursing staff found the resident unconscious, lying on the ground.

Law enforcement records indicated a staff member called 911 because they found the resident "not breathing." The records indicated a staff member told law enforcement the resident "could possibly be dead." When law enforcement arrived, they found the resident with no pulse and not breathing so they began resuscitation efforts (CPR). CPR efforts were ineffective, and they pronounced the resident deceased. After emergency responders performed CPR, facility staff gave them the resident's, Do Not Resuscitate (DNR), paperwork which indicated the resident did not want resuscitative measures. Additionally, there was a delay of approximately 13 to 27 minutes before staff contacted emergency services (911) after they found him not breathing because they attempted to call the facility nurse. Staff made multiple calls to the facility nurses because there was confusion over which nurse, they were supposed to contact. There were two staff members working in the facility during the incident and both told law enforcement the facility required them to contact the nurse prior to calling 911. Law enforcement records indicated they reviewed video footage of the incident to confirm the timing of events that occurred during the night.

During an interview, a nurse said she received a call from a staff member during the night but did not answer because she was not "on call." The nurse said she noticed staff left her a voice mail, so she listened to the message which indicated there was a possible death. The nurse said she called the staff member back and told her to call 911, because the resident was not on hospice services. The nurse said she told the staff member to call her after she called 911 so she could tell her how to get the resident's paperwork ready for the responders. The nurse said

there was a series of phone calls made between her and the staff member before the staff member called 911. The nurse said the staff member should have called 911 once they noticed the resident was not breathing, then contacted the nurse.

The facility emergency policy instructed staff to first contact the nurse in emergencies prior to calling 911. Later, during the onsite visit, the facility provided the same policy to the investigator which had the instructions to contact the nurse first removed.

The medical examiner report indicated the resident died because of complications of Lewy body dementia and Parkinson's disease.

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" means:
(a) 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. Deceased.
Family/Responsible Party interviewed: No. Declined Interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility provided education to staff members how to respond in emergencies.

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.

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
	31761	A. BUILDING: _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES GRACEWOOD	675 MARKET PLACE DRIVE LINO LAKES, MN 55014

(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 ASSISTED LIVING PROVIDER LICENSING 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: #HL317617575C/#HL317614446M On September 15, 2023, 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 thirty-two residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL317617575C/#HL317614446M, tag identification 1380.	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 License Providers. 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 surveyors' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
01380 SS=I	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 1 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-B and ULP-C, were competently trained in observing, reporting, and documenting resident's status. This had the potential to affect all of the licensee's current residents. Staff failed to alert emergency responders (911) in a timely manner after finding R1 was not breathing. Additionally, staff failed to provide responders with R1's physician orders for life sustain treatment (POLST), and do not resuscitate (DNR) documents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	01380		

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01380	Continued From page 2 portion or all of the residents). The findings include: R1 was admitted for diagnoses including Lewy body dementia, Parkinson's disease, hallucinations, and frequent falls. R1's POLST dated February 9, 2022, indicated, "Do not attempt resuscitation/DNR (allow natural death)." R1's progress notes dated December 30, 2022, at 5:20 a.m., indicated registered nurse (RN)-A received a phone call at 3:48 a.m., but she did not answer the phone. ULP-B left a message regarding a possible death. RN-A called ULP-B who told her she found R1 lying on the ground directly in front of his bed, unconscious. RN-A told ULP-B to call 911 and notify the nurse who was on call. RN-A called ULP-B at 3:58 a.m., to ensure she called 911. ULP-B said she did not call 911 and could not get ahold of the on-call nurse. RN-A told ULP-B, "If you have someone that you believe has passed away and is not on hospice, you all 911 immediately," RN-A called ULP-B at 4:13 a.m., and ULP-B said first responders were performing CPR on R1. ULP-B failed to give emergency responders R1's physician orders for life sustaining treatment (POLST). R1's progress notes indicate RN-A "educated ULP-B." Law enforcement records dated December 30, 2022, indicated ULP-B and ULP-C were caregivers from a staffing agency. The records indicated both staff appeared to be inadequately trained to recognize death and the need to call 911 in a timely manner. The ULP's delayed contacting emergency responders for thirteen to twenty-seven minutes after finding R1 unresponsive. Both ULP's told law enforcement	01380		

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01380	Continued From page 3 they were required to call a nurse prior to contacting them and both ULP's were unaware if R1 had a DNR/POLST in place. On September 15, 2023, at 12:18 p.m., RN-A said ULP-B and ULP-C worked the night R1 passed away. RN-A said neither ULP gave emergency responders R1's POLST which was located on the med cart. RN-A said on the night of R1's passing, ULP-B and ULP-C should have called 911 when they noticed R1 was not breathing, then they should have called the nurse, and the POLST should have been ready for emergency responders when they walked in the door. On September 15, 2023, at 12:49 p.m., regional director (RD)-D gave surveyor documentation from the licensee's internal investigation. Included in the documentation was a copy of the licensee's, 2.21 Emergency/911, policy dated August 1, 2021. The policy description indicated staff would call 911 to summon assistance and aide when handling emergency situations. Right after the policy introduction, the procedure for doing so read as follows, "1) Call Nurse First in an Emergency, 2) Call 911 if a Significant Adverse Emergency Exits ..." This policy was in place at the time of the incident. On September 15, 2023, at 1:34 p.m., RD-D gave surveyor a copy of the licensee's, 2.21 Emergency/911, policy dated August 1, 2021. The policy description indicated staff would call 911 to summon assistance and aide when handling emergency situations, however the direction for staff to call the nurse first was removed. TIME PERIOD FOR CORRECTION: Seven (7) days	01380		

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