State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326472601M
Compliance #: HL326471817C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:
The Homestead at Rochester
5530 Ballington Road NW
Rochester, MN 55901
Olmsted County

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

Evaluator's Name: Erin Johnson-Crosby, 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 alleged perpetrator (AP) abused the resident when the resident was found lying on the floor bleeding with lacerations to her face, cheeks, and bruising in various stages of healing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident was found on the floor covered in blood; however, there was no evidence to support that the resident's injuries were a result of abuse by facility staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, facility documentation, personnel files, staff schedules, a law enforcement report, and related facility policies and procedures. Also, the investigator observed resident cares and staff interactions.

The resident resided in an assisted living memory care unit with a diagnosis of dementia. The resident's service plan included assistance with supervision and stand by assistance with morning and evening cares, bathing, toileting, and medication administration. The resident's assessment indicated the resident had memory loss, confusion, and was at risk for falls.

The resident's medical record indicated staff found the resident on the floor bleeding in their apartment and staff contacted 911 for emergency assistance.

Facility documentation indicated evening staff administered an anti-anxiety medication to the resident earlier that evening for restlessness and agitation. Staff documented that the medication was effective. Evening staff assisted the resident to bed then checked on the resident at 8:00 p.m. and noted that the resident was asleep. Night shift staff checked on the resident around 1:20 a.m. and found the resident laying on the floor bleeding. The staff contacted the nurse and then called 911. Staff documented that the resident received Xarelto (blood thinner) which could have contributed to the amount of bleeding noted with injuries.

Hospital records indicated that the resident arrived at the emergency room with several facial lacerations (cuts), abrasions (bruises) along the anterior (front) scalp and periorbital (around the eye) edema and a significant amount of dried blood in the resident's hair. The record indicated the possibility of non-accidental trauma related to the multiple bruises in different stages of healing but was later ruled out. The records indicated the resident returned to the facility three days later.

The Police report indicated the resident fell during the middle of the night and a crime did not occur.

During an interview, unlicensed personnel (ULP) #1 stated she arrived to work at 10:30 p.m., the night of the incident. This was her first time working on that unit and was oriented to the residents by another staff member. She was told the resident was independent. ULP #1 started checking on the residents about 12:30 p.m., and got to the resident's room around 1:00 a.m. When the ULP opened the resident's door she found the resident on the floor covered in blood. The ULP did not know where the blood was coming from and called ULP #2 for assistance.

During an interview, ULP #2 stated she received a call from ULP #1 stating the resident fell and there was blood all over. When ULP #2 arrived, she saw the resident laying on the floor with a pillow under her head and was covered in blood. ULP #2 called the nurse and was directed to call the 911. ULP #2 stated ULP #1 was distraught and did not want to be left alone after the incident.

During an interview, the registered nurse (RN) stated the internal investigation determined the resident's service plan was followed at the time of the fall. It was determined after facility staff found the resident on the floor, staff followed facility protocol and contacted the RN and then called for emergency assistance.

Attempts to contact the resident's family member were unsuccessful.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No; resident deceased
Family/Responsible Party interviewed: No, attempts to contact were unsuccessful
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the incident to the state agency and completed an internal investigation.

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
	32647	A. BUILDING: _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(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 June 12, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL326471817C/#HL326472601M. No correction orders are issued.	0 000		