Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326476806M
Compliance #: HL326472819C

Date Concluded: February 14, 2024

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

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

Evaluator's Name: Deb Schillinger RN, Special Investigator

Finding: Substantiated, facility responsibility

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 facility did not adequately address the resident's change in condition which led to skin breakdown.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although unlicensed caregivers raised concerns about the resident's overall condition and new skin breakdown, the facility did not provide adequate follow-up. At the end of three days, the resident required hospitalization and admitted to the intensive care unit.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the family member. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures.

The investigation included an onsite visit, observations, and interactions between current residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included advanced dementia. The resident's service plan included assistance with transferring and toileting. The resident's assessment indicated the resident transferred with the assist of one unlicensed caregiver and was wheelchair dependent. The same documents indicated the resident had both short-term and long-term memory loss, poor judgement, and was unable to make her own decisions.

The resident's medical records indicated the resident had a decline in her condition which was identified by the unlicensed caregivers over a long holiday weekend. The same documents indicated by the end of the weekend, a Tuesday, she required hospitalization.

On the Saturday before the resident's hospitalization, a nurse note entered by nurse #1 indicated the resident had not been eating well for a couple of days. The same document indicated nurse #1 spoke with the resident, who said she was "just not feeling hungry lately".

On the same day, a form titled, "Weekly Skin Assessment" indicated the resident had skin breakdown in the coccyx area (tailbone), and unlicensed caregiver #1 informed an on-call nurse of the new skin breakdown.

A late entry nurse note dated the same day, but with a computer timestamp for nine days after the resident's hospitalization, indicated nurse #1 received the updates regarding the resident's skin and decline. The same document indicated the unlicensed caregivers provided a photo of the resident's skin breakdown over the weekend. Nurse #1 provided instructions to clean the wound and apply Mepilex (a wound dressing) until an assessment could be done on Tuesday.

A review of the medical record did not identify nurse follow up on Sunday or Monday over the holiday weekend.

When contacted, the medical provider's clinic indicated no documentation of communication or updates from the facility over the holiday weekend regarding the resident's condition.

During an interview, the resident's family member stated she received an anonymous phone call from the facility expressing concern about the resident's cares on Monday (a holiday). The family member stated she visited the next day and found the resident less responsive than normal, looking dehydrated, and weak. The family member stated she demanded the resident be transferred to the hospital. The family member stated she had not received any calls from the facility over the weekend other than the anonymous call.

When the resident went to the hospital on Tuesday, the hospital records indicated the resident admitted with septic shock secondary to urinary tract infection, infected skin wound near her

tailbone, and an unstageable pressure injury (the stage of the wound could not be determined) with dead tissue on her right buttock area.

During an interview, unlicensed caregiver #1 stated the nurse on-call was notified of the resident's concerns including her general decline and skin breakdown. Caregiver #1 stated two nurses were notified of the resident's skin breakdown. The unlicensed caregiver said she notified the nursing staff more than four times.

During an interview, an unlicensed caregiver #2 stated the nurse was notified several times of change in the resident's condition over that weekend. She stated the resident became so weak she required the assistance of two caregivers to transfer. Unlicensed caregiver #2 stated she sent a photo of the resident's breakdown to the nurse in her efforts to convey her concern.

On-Call Schedule
A review of the facility schedule indicated that nurse #1 was on call for Saturday and Sunday, while another nurse, nurse #2, was on call Monday and Tuesday.

The investigation included a request of the facility to confirm who on was on-call during that weekend, but the facility was unable to provide this information.

During an interview nurse #1 stated she could not recall information regarding the period. When told she was listed on the schedule as on-call for part of the weekend, she stated she was not on-call.

During an interview, nurse #2 states she was not on-call for the holiday weekend, thought nurse#1 was on-call but could not be sure. Nurse #2 stated she could not remember if the resident had chronic skin issues and was unable to recall any other information during that weekend.

A third nurse was interviewed, nurse #3, and stated she did not recall any information about the incident.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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 was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

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 01/03/2024

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 January 2, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL326473314C/#HL326477005M and #HL326472819C/#HL326476806M. The following correciton order is issued for HL326476806M: 2360.	0 000	No plan of correction required.	
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility 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 required.	

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