Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331671681M
Compliance #: HL331679251C

Date Concluded: August 1, 2024

Name, Address, and County of Licensee Investigated:
Serenity Place on 7th
329 7th Avenue Southeast
Saint Joseph, Minnesota 56374
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 facility neglected the resident when staff noticed the resident may have been intoxicated. Four hours later, staff found the resident on the floor with dried blood pooled next to her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility was aware of the resident's alcohol use disorder and related frequent falls due to alcohol use. Although the facility did not document all interventions provided, there was evidence of updating the resident's medical provider after each fall, including falls related to intoxication, the facility sent the resident to the hospital after falls with injury, and the facility arranged for the resident to complete outpatient chemical dependency treatment until arranging for inpatient treatment.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of the resident record, hospital records,

facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed the resident's ability to walk independently, as well as her apartment for clutter and set up.

The resident resided in an assisted living facility. The resident's diagnoses included gait instability and a history of alcohol abuse. The resident's service plan included assistance with supervision and behavior management related to alcohol use. The service plan did not include safety checks at night.

The resident's medical record included progress notes and incident reports which indicated the resident fell multiple times related to alcohol consumption and averaged approximately one fall every one to two months. The resident's record also included the communication to the medical provider and the provider's response related to each fall. The provider did not implement medication changes or special instruction other than the resident should not be drinking.

A few months prior to the allegation, the resident had a fall related to alcohol consumption. The facility implemented new interventions with included resident encouragement by facility staff to wear her call pendant, use her assistive devices as appropriate, participate in community activities, increase hydration, notify staff of concerns as needed. Nine days later, the resident had a fall while intoxicated, hit her head, and went to the emergency department for evaluation. The resident's provider wrote back to the facility after an update indicating the resident should not be drinking due to medication usage and frequent falls, but did not include parameters regarding medication use when the resident chooses to drink.

The resident's medication administration record (MAR) included medications with a high risk of negative side effects with alcohol use including Lyrica (anti-seizure medication used for pain), aspirin (used for anticoagulation), and duloxetine (anti-depressant). The medication order did not include instructions for staff to contact the nurse when the resident was drinking alcohol. The MAR also included an as needed medication, Rimegepant (for headaches) with instructions of do not give with alcohol. Although there were not specific instructions on the MAR, the MAR did include notes staff contacted the registered nurse (RN) when the resident had been drinking and received nursing orders to hold the medications.

Two months after the resident's previous falls, the resident had another fall while at exercise group and did not indicate the fall was related to alcohol. However, under the section of interventions a new intervention included "no alcohol use," however did not indicate how staff should enforce no alcohol usage of the resident. Three days later the resident had another fall from sliding out bed, but the incident report did not indicate it was related to drinking alcohol.

The next month, the resident had another fall while drinking alcohol without injury. Staff found the resident sitting on the floor with her call pendant in reach, but the resident did not active it. The resident's medical provider did not provider any new orders or instructions.

A few weeks later, an incident report indicated the resident fell twice in 12 hours. The resident denied alcohol use but had been slurring her words and had difficulty with word finding. The report included a section to indicate actions taken by the facility to prevent future falls. This section failed to identify newly implemented interventions from previous interventions. The facility updated the resident's medical provider who wrote back "noted."

The resident's assessment indicated the resident had a history of alcohol abuse, and staff were to monitor and record any signs of use daily and update the provider as needed. The assessment identified the resident as independent with walking. The assessment also identified the resident as at risk for falls and indicated the resident had safety checks due to concerns of alcohol consumption but failed to indicate the frequency of safety checks. Interventions remained the same as previous interventions identified in the incident reports.

The service delivery record failed to include safety checks other than the daily wellness check as identified in the assessment as an intervention.

Although, the resident's assessment and previous incident report did not include new interventions, the resident's service delivery record during an alcohol use shift note indicated the resident did not have signs of alcohol use and attended outpatient chemical dependency treatment. Staff wrote the note three days after the last incident report. The service delivery record included another note a week later indicating she attended her outpatient chemical dependency treatment.

The resident's service delivery record indicated six days prior to the resident's fall related to the allegation, the facility updated the resident's service delivery record to include an additional monitor and document if the resident used alcohol for all three shifts (documenting at the end of the shift) at 6:00 a.m., 1:00 p.m. and 10:00 p.m.

A week after the resident's last outpatient treatment attendance, the resident's service delivery record indicated the resident had last been outside at 2:00 a.m. and appeared very intoxicated. Staff spoke with the resident who stated she would come back inside and go to bed.

An incident report indicated at 6:10 a.m., staff found the resident on the floor while intoxicated with a severe nosebleed resulting in her face and hair covered in blood. The resident had been trying to reach her pendant for some time based on the dried blood on the floor. The staff sent the resident to the emergency department for evaluation. The incident report indicated intervention of the resident continuing with outpatient treatment four times per week. The resident's medical provider responded with instruction the resident may come to clinic to discuss substance abuse.

The resident's hospital records indicated the resident said she fell around 4:00 a.m. when she slipped and hit her nose. The hospital completed imaging which found no concerns. The hospital also completed lab work and found the resident had an elevated blood alcohol level.

The resident remained in the ER until clinically sober, then returned to the facility with diagnoses of a fall and swollen nose.

Two weeks later, the resident's incident report and medical provider communication indicated she had another fall and two hour safety checks were implemented as well as updating the family and treatment center. Another two weeks later, after a subsequent fall, the medical provider sent a referral at the facility's request for an inpatient treatment program. The resident's orders included a new order four days later after the referral to start naltrexone (medication for alcohol abuse) and the next day the inpatient chemical dependency program accepted the resident for admission.

During an interview, the RN stated if there was a concern a resident would be at risk for any safety issues while intoxicated, then the facility would look at revising the service plan for more frequent monitoring. The RN stated the resident was her own responsible party and went to the store on her own to buy alcohol. The facility staff were beginning to see a patten of the resident's alcohol use, so they began watching her closer during the times they suspected her of being intoxicated. The facility did not have a formal policy written for alcohol use, and most residents were able to make their own decisions regarding their life choices. After the incident of the severe nosebleed, the facility started completing safety checks every two hours during the overnight shift, and they were able to get her into an inpatient treatment facility a few weeks later. The facility also encouraged the resident to use her pendant, as she had not been wearing it during the incident, and to use staff assistance while intoxicated. After the incident, the facility also held a meeting with the resident and her alcohol counselor to discuss what staff were seeing in the facility.

During an interview, an unlicensed personnel (ULP) stated if a resident appeared to be under the influence of alcohol, they just kept an eye on them. If the resident became uncooperative, they would call the nurse for instructions on what to do, otherwise, they passed on the signs the resident had been drinking during shift change. They did not check on the resident when they suspected she had been drinking prior to the incident because it was not on the service schedule.

In conclusion, the Minnesota Department of Health determined neglect 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.

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. Resident declined to interview.
Family/Responsible Party interviewed: No. Attempts to schedule interview were unsuccessful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility helped the resident get a prescription for a medication to help with alcohol cravings, implemented safety checks, encouraged pendant use and staff assistance while intoxicated, and assisted the resident with getting into inpatient treatment.

Action taken by the Minnesota Department of Health:
No further action taken.

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
	33167	A. BUILDING: _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY PLACE ON 7TH	329 7TH AVENUE SE SAINT JOSEPH, MN 56374

(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 July 3, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL331679251C/#HL331671681M. No correction orders are issued.	0 000		