Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339753185M
Compliance #: HL339753299C

Date Concluded: August 20, 2024

Name, Address, and County of Licensee Investigated:
Maple Woods Assisted Living
33310 State Hwy 6
Deer River, MN 56636
Itasca county

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

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected the resident when the AP failed to follow the resident's plan of care which resulted in a fall with a fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP did not follow the resident's plan of care while assisting him with transferring from his bed to his WC. The AP attempted to transfer the resident by herself from his bed to his wheelchair using a bear hug lifting method. The resident's plan of care required transfer assistance of two staff members and a full body mechanical lift (Hoyer lift).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, death record, hospital records, facility internal investigation, facility incident reports, personnel

files, staff schedules, and related facility policy and procedures. While on site, the investigator observed staff assisting residents with transfers.

The resident resided in an assisted living memory care unit. The resident's diagnoses included vascular dementia with behaviors and stroke. The resident's service plan included assistance with transfers and repositioning. The resident's assessment indicated the resident was his own decision maker and could be resistive to care. The resident had noted verbal and physical aggression towards staff at times and used a wheelchair for mobility. The resident's assessment indicated he required the assistance of two staff members and a full body mechanical lift for transfers.

The resident's plan of care indicated the resident required two staff members to assist with transfers with the use of a Hoyer lift (mechanical full body lifting equipment). The service delivery record included the directive to unlicensed personnel (ULP) for the resident's transfer services.

An internal investigation report indicated the AP was assisting the resident from his bed to his wheelchair by herself when the resident sustained a fall. The resident stated his knee started to hurt when he got up. Facility staff called emergency medical services (EMS) and EMS transported the resident to the emergency room for evaluation.

The resident's hospital record indicated he admitted to the hospital the day after the fall and completed a surgical repair 10 days after hospital admission. The resident was in the hospital for 16 days before returning to the facility for continued care.

The resident passed away 20 days after returning to the facility. The resident's death record indicated the cause of death was complications of hip fracture with surgical repair.

During investigative interviews, multiple staff members stated a resident's care needs were in Rtasks (an online records and documentation system used by the facility). The staff stated ULP had access to Rtasks. The facility required staff to check it frequently and before they care for a resident to be aware of the residents needs or any changes to their needs.

During an interview, ULP 1 stated the resident was exhibiting behaviors just prior to the fall. ULP 1 stated the AP asked her to assist with getting the resident to comply with transferring to his wheelchair, but he was refusing. ULP 1 stated she left the residents room when he was refusing to transfer. ULP 1 stated the fall could have been prevented if the AP had another person to help her transfer the resident.

During an interview, ULP 2 stated the resident always required the assistance of two staff for transfers.

During an interview, a licensed practical nurse (LPN) stated the resident did not initially need the assist of two people when he first came to the facility. The LPN stated the resident declined behaviorally and physically, and then always required the assist of two people. The LPN stated the AP did not ask her to help transfer the resident the day the resident fell.

During an interview, the administrator stated she expects all ULP to know the resident's care needs before providing care to them. The administrator stated if there was not a second ULP available to assist a resident who required the assist of two, they should call the nurse for further direction. The administrator felt the fall was preventable if the AP had followed the resident's plan of care to have two caregivers assist in transferring him.

During an interview, a registered nurse (RN) stated all ULP receive training on how to properly use the mechanical lifts. The RN stated ULP are expected to be aware of a residents' care needs in Rtasks prior to providing care.

During an interview, the AP stated she received online and in person training with competencies on how to transfer residents using a mechanical lift. The AP stated she was able to see the care a resident required in Rtasks. The AP stated the resident could stand on his own and only needed to use the mechanical lift if he was exhibiting behaviors. The AP denied the resident was having behaviors prior to the fall. The AP stated she used a bear hug method to transfer the resident and while turning towards his wheelchair to sit, he sat down too soon and landed on the floor on his buttocks. The AP stated there were times in the past she had asked another staff member or a nurse to help her transfer the resident.

The AP's training record indicated she passed competencies administered by a RN for resident transfers prior to the incident. The competency administered did not include using a bear hug method.

The facility policy for ambulating a resident does not include the use of a bear hug method.

In conclusion, the Minnesota Department of Health determined neglect was substantiated. Do not elaborate this sentence.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, unable to contact.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility called emergency medical services to transport the resident to the hospital for evaluation.

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.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33975	A. BUILDING: _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	33310 STATE HIGHWAY 6 DEER RIVER, MN 56636

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: HL339753299C/HL339753185M HL339753936C/HL339753621M On July 9, 2024, through July 10, 2024, 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 20 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL339753299C/HL339753185M, tag identification 1640, 2360. The following correction order is issued for HL339753936C/HL339753621M, tag identification 1620, 2360.	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 Facilities. 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 evaluators' 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 SUBDIVISION 1-3.	
01620 SS=J	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to identify and complete a change of condition assessment, as required for 1 of 1 residents (R1) reviewed. R1 developed excessive drooling, a protruding tongue, slurred speech, had teeth removed while residing at the facility, and had a noted behavior to "scarf" food down at mealtimes, placing the resident at risk for choking. The resident died at the facility due to choking on food. This practice resulted in a level four violation (a	01620		

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01620	Continued From page 2 violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis includes schizophrenia and anxiety. R1's service plan dated March 30, 2024, indicated R1 received behavior management and safety checks. The assessment did not indicate R1 received meal services. R1's provider contact form dated March 27, 2024, at 5:39 p.m., indicated R1 had an order for glycopyrrolate (used for excessive secretions) to be used as needed since May 23, 2023. R1's discharge assessment dated May 20, 2024, included R1's last assessment dated April 2, 2024, completed by registered nurse (RN)-J, indicated R1 had all upper teeth removed on October 17, 2023 and some remaining bottom teeth were missing. The same document indicated R1 was independent with eating and had no difficulty swallowing. The assessment indicated R1 had a regular diet, although she had no upper teeth. R1's dental appointment note dated April 12, 2024, indicated R1 had her upper teeth removed about two months ago. The noted indicated she had further extractions done by the oral surgeon. The note indicated a prior authorization was submitted for full upper denture and lower partial denture. R1's record lacked a nursing assessment of R1's	01620		

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01620	Continued From page 3 nutrition and eating ability related to teeth removal and awaiting need for dentures. R1's nurses notes dated April 24, 2023, at 10:47 a.m. indicated R1's mental health support staff, brought to nursing staff's attention an increase in drooling and slurred speech. RN-J also noted R1 was drooling more. R1's nurses notes dated April 29, 2024, at 1:14 p.m. indicated a semi annual meeting was held with R1's support team for concerns they had. The mental health support staff brought up concerns of R1 being more mentally slow, increase in drooling, tongue hanging out and showing abnormal presentation. The note lacked documentation of response or outcome of the meeting. R1's record lacked a nursing assessment for a change in condition of R1 presenting with increased drooling, abnormal tongue presentation and delayed mentality. R1's nurses notes dated May 1, 2024 at 12:34 p.m., indicated R1 was seen in house by her provider. RN-J indicated the provider was updated on the semi annual meeting and requested a referral to neurology. The provider did not feel a referral was warranted. The provider gave an order to increase R1's glycopyrrolate. The medications was scheduled routine in the morning in addition to the standing as needed order. R1's record lacked a nursing assessment to determine the effectiveness of the increase of glycopyrrolate, following up on any concerns with eating or need for diet modifications related to teeth removal, increased drooling, abnormal	01620		

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01620	Continued From page 4 tongue presentation and slurred speech and delay in mentality. R1's nurse notes dated May 17, 2024, at 7:24 p.m., indicated R1 was eating a sandwich in the dining room. At 12:17 p.m., R1 entered the kitchen with her hands by her throat and stated to staff she was choking. Staff encouraged R1 to cough. R1 was no longer able to speak, and staff gave abdominal thrusts to R1. Staff assisted R1 to sit in a chair and continued abdominal thrusts. R1 fell to the floor from the chair. Staff called 911. Staff rolled R1 on her back and noted R1 was not breathing and did not have a pulse. Staff started chest compressions. Staff continued compressions until emergency medical services (EMS) arrived. EMS continued life saving measures until 1:23 p.m., when a medical doctor gave direction to stop life saving measures. R1 was pronounced deceased at 1:35 p.m. During an interview on July 23, 2024, at 3:10 p.m., kitchen staff (K)-E stated she was the staff that assisted with the Heimlich maneuver and cardiopulmonary resuscitation (CPR) of R1. K-E stated lunch served Philly cheese steak sandwiches that R1 had choked on. R1's death record indicated R1's cause of death on May 17, 2024 was choking with the onset of death in minutes. R1 choked on a food bolus. During an interview on July 23, 2024, at 9:00 a.m., family member (FM)-D stated she was concerned with R1's excessive drooling and had addressed it to many staff at the facility. FM-D stated she did not receive any response from staff about her concern. During an interview on July 25, 2024, at 10:00	01620		

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01620	Continued From page 5 a.m., licensed practical nurse (LPN)-G stated R1 did not have any teeth that she knew of. LPN-G stated R1 liked to eat fast, and staff had to tell her to slow down. LPN-G stated eating food fast and excessive drooling was a risk for choking. During an interview on July 25, 2024, at 2:00 p.m., licensed assisted living director (LALD)-H, who was also a LPN, stated a nurse should do an assessment with any change of condition. LALD-H stated R1 "scarfed" her food at times, but staff did not note R1 as eating in an unsafe manner. LALD-H stated excessive drooling, lack of dentition and eating food very fast could be risk factors for choking. During an interview on July 31, 2024, at 2:00 p.m., registered nurse (RN)-I stated an RN should assess a resident any time there is a change in condition, or concerns noted. RN-I stated excessive drooling, lack of dentition and eating food very fast were a risk factors for choking. RN-I stated the onset of excessive drooling and removal of teeth was a change in condition of a resident. RN-I stated the day of R1's death the nurses were at another location and the activity staff called to report R1 was choking. RN-I stated they were put on speak phone to ask staff if they had called 911. She gave verbal directions to K-E to check the airway and keep the beat for CPR. When emergency services arrived, the requested her to go to the facility to confirm R1's death. RN-J failed to respond for an interview. The licensee-provided policy titled Initial and On-Going Nursing Assessment of Residents dated February 19, 2023, indicated a RN will complete a nursing assessment as needed based	01620		

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01620	Continued From page 6 upon resident condition. The RN will complete a comprehensive nursing assessment of the residents needs for a change in the resident's condition and as indicated by individual resident circumstances including eating, dental status and oral care. The policy indicated the RN will update the service plan based on the resident's needs. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

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01640	Continued From page 7 Based on observation and document review, the licensee failed to authentication for services from the resident, as required for 1 of 1 residents (R2) reviewed. R2's service plan lacked the signature of R2 or a representative of R2. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnosis included vascular dementia with behaviors and stroke. R2's Individual Abuse Prevention Plan dated May 16, 2024, indicated R2 was his own decision maker. R2's Service Plan dated May 21, 2024, indicated R2 received assistance with toileting, transfers, and behavior management. R2's service plan lacked R2's or R2's representative signature. The space provided on the document for the R2's signature contained the signature of the facility's licensed assisted living director. The space provided on the document for the facility representative contains the signature of a facility registered nurse. R2's assessment dated May 3, 2024, indicated R2 was independent with financial and care decisions. During an interview on July 25, 2024, at 10:00 a.m., licensed practical nurse (LPN)-D stated R2	01640		

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01640	Continued From page 8 was his own person and it was difficult for staff to make an accurate assumption of R2's thinking. LPN-D stated towards the end of his life, R2 didnt know what he wanted. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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 two of two resident(s) reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred. The facility was responsible for the maltreatment, in connection with incidents which occurred at the facility involving R1. An individual person was for the maltreatment, in connection with incidents which occurred at the facility involving R2. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	