Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339753621M
Compliance #: HL339753936C

Date Concluded: August 29, 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, 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 resident choked on food and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. While there was a primary registered nurse (RN) at the facility, management and nursing staff completed work between two different locations. The facility staff were aware of noted changes in the resident's eating and swallowing but failed to conduct a change in condition assessment. The facility failed to initiate interventions to help prevent the resident from choking and provide supervision when eating.

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

schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed meal service while on site.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and anxiety. The resident's service plan included assistance with medication administration and behavior management. The resident's assessment indicated she walked independently and was independent with feeding herself. The assessment indicated the resident was alert, oriented and had no prior history of difficulty swallowing or aspirations.

The resident's medical record and physician orders had documented diagnoses of tardive dyskinesia, a side effect of anti-psychotic medications causing involuntary movements of the face, tongue or other body parts. The resident's physician orders included an order for Ingrezza (a medication to treatment tardive dyskinesia symptoms) scheduled once daily and an order for glycopyrrolate (a medication used to reduce secretions) to use for excessive secretions once every 8 hours as needed. The resident had the as needed glycopyrrolate prescription ordered one year prior to the incident.

The nurse's notes indicated the resident's psychiatrist saw the resident via virtual appointment to address medication management and for excessive drooling. The progress note indicated the resident utilizes the medication she has (glycopyrrolate) almost daily for excessive drooling, which is effective when used. The medical provider notes of the visit indicated the resident should follow up with excessive drooling with her primary care provider (PCP). The psychiatrist ordered an increase in dosage of Ingrezza.

The resident's nursing assessment, completed by RN 1 six days after the appointment, indicated the resident had all upper teeth removed and some bottom teeth missing. The assessment indicated the resident was independent with eating and had no difficulty swallowing. The assessment indicated the resident had a regular diet, although she had no upper teeth.

Ten days after the nursing assessment, the resident had a dentist visit. The dental notes indicated the resident had all her upper teeth removed two months prior to the visit. The dental notes indicated additional teeth were removed at the visit. The dentist submitted an insurance prior authorization for a full upper denture and a partial lower denture for the resident.

The facility failed to assess the resident's nutrition and eating ability related to teeth removal and awaiting need for dentures.

Twelve days later, the resident's progress notes indicated the resident's mental health support staff brough concerns to RN 1 about the resident's increased drooling and slurred speech. RN 1 documented she also noted increased drooling from the resident.

Five days later, the resident's progress notes indicated a care team meeting was held with the resident's mental health support staff. The staff brought up concerns of the resident being

more mentally slow, eyes looked more tired, increase in drooling, and a protruding tongue not of her norm. The mental health support staff wondered if medications were causing these symptoms and requested an increased of her medication for drooling.

The facility failed to conduct a change in condition assessment of the resident presenting with increased drooling, abnormal tongue presentation and delayed mentality.

Two days later, the resident's progress notes indicated the RN 1 sent a fax to both the resident's psychiatrist and PCP that the resident's mental health support staff brought to the facility nursing staff's attention she had an increase in drooling and slurred speech. The RN documented in the note she also had noted increased drooling but indicated the resident's speech had been at baseline with slurring her words at times.

Another two days later, the resident's PCP evaluated the resident for concerns of increased drooling, slurred speech and appearing more tired with hazed eyes. The PCP noted concerns of fairly continuous drooling and ordered a scheduled morning dose of glycopyrrolate in addition to the as needed order. The PCP documented she felt concerns were related to tardive dyskinesia and should be addressed by psychiatry.

A progress note of a fax communication to the resident's psychiatrist the same day as the PCP visit, indicated staff updated the psychiatrist of the PCP's new order. The note indicated the resident's mental health support staff have reported the resident was displaying seizure like activity. It was discussed with the PCP, however the PCP felt that was related to tardive dyskinesia and a virtual visit with psychiatry was scheduled in three weeks. The RN noted there was no response from the psychiatrist.

The resident's medical record failed to indicate the facility staff reported to the medical providers amongst the changes in the resident's increased drooling and slurred speech, the resident also had teeth removed to address evaluation of the resident's safety with eating.

The facility failed to advocate for diagnostics to determine the cause of the symptoms while the resident's psychiatrist and PCP deferred evaluation to each other over two months, including a speech evaluation to determine appropriate diet and if any swallowing concerns arose from significant teeth removal and changes in mentality.

During investigative interviews, multiple staff stated there was not constant supervision in the dining room, but staff were nearby the dining room when passing through the dining room, kitchen, or hallways completing other tasks.

During an interview, an activities staff member stated the resident "scarfed" her food down and staff would have to tell her to slow down.

During an interview, a kitchen staff member stated the resident had her teeth removed. The staff member stated the resident could not chew food once she had her teeth removed but was able to chew once her gums healed. The staff member stated the resident would inhale her food.

The resident's medical record lacked a change of condition assessment to address the resident's change eating or swallowing status related to excessive drooling, abnormal tongue presentation, slurred speech, lack of oral dentition and need for dentures, and behavioral concerns for resident "scarfing down" her food during meals. The resident's record lacked indication nursing staff monitored or assessed the resident's safety with eating to determine what needs or assistance the resident would have. The resident's service delivery record lacked documentation of interventions or monitoring in relation to the resident's change in eating/swallowing status. As a result, resident's plan of care remained that the resident was independent with eating and maintained a regular diet.

An incident report indicated during lunch, the resident entered the kitchen area with her hands by her throat and stated she was choking. The kitchen staff encouraged the resident to cough. The resident lost her ability to speak further, and the kitchen staff member initiated the Heimlich maneuver. The staff member assisted the resident to a sitting position in a chair and continued to perform the Heimlich maneuver at which time the resident became unconscious and fell to the floor. The kitchen staff member began cardiopulmonary resuscitation (CPR) efforts while another staff member called 911. Emergency medical services (EMS) arrived at the facility and continued life saving measures. EMS pronounced the resident deceased at the facility after life saving measures were unsuccessful.

The resident's death record indicated the cause of death was choking.

During an interview, the kitchen staff member stated she was the staff that assisted with the Heimlich maneuver and CPR of the resident. The kitchen staff member stated lunch served Philly cheese steak sandwiches that the resident choked on.

During an interview, RN 2 stated an RN performs an assessment any time there is a change in condition of a resident. RN 2 stated excessive drooling, lack of dentition and "scarfing" down food habits could be a risk for choking. RN 2 stated the onset of excessive drooling and having teeth removed is a change in condition. RN 2 stated the day of the resident's death, the nurses were at another location and not at the facility. The activity staff called to report the resident was choking and put her on speaker phone so she could help direct the kitchen staff member to check the resident's airway and keep the beat for CPR. RN 2 stated EMS requested she come to the facility to confirm the resident's death.

During an interview, the licensed assisted living director (LALD), who was also a licensed practical nurse (LPN), stated a change in a resident's eating habits would be a change in condition and the RN should complete an assessment with any resident change of condition.

The LALD stated the resident “scarfed” her food at times, but staff did not note the resident to be eating unsafely.

During an interview, an LPN stated the resident did not have any teeth that she knew of. The LPN stated the resident liked to eat fast and staff had to tell her to slow down. The LPN did not recall any interventions placed for the resident’s risk of choking.

RN 1 did not return multiple call attempts for an interview.

During an interview, a family member stated the resident had excessive drooling. She addressed her concern about it to multiple staff members and never received a response to her concern from any staff.

In conclusion, the Minnesota Department of Health determined neglect 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.

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

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

The facility 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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility attempted life saving measures to the resident and activated emergency medical services promptly.

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

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
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Medical Practice

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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	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

(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
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.	