Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349801241M
Compliance #: HL349801997C

Date Concluded: October 18, 2022

Name, Address, and County of Licensee Investigated:

Shiloh Assisted Living
5384 County Care Ln
Pequot Lakes, MN 56472
Crow Wing County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 emotionally abused the resident when the resident was isolated from contact with family after the facility instructed family members to shut off the resident's phone and stay away for a couple of days/weeks to allow the resident time to adjust.

The facility neglected the resident when they failed to identify a change in the resident's condition including increased weakness, increased falls with bruising of his eye, and loss of appetite. When the resident was transferred to the emergency department (ED), it was

identified the facility had administered too much coumadin (an anticoagulant blood thinning medication used to treat blood clots) in error, which caused the residents blood to be too thin. The resident had gastrointestinal bleeding and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident was able to call family using his personal cell phone, and family visited the resident regularly.

The Minnesota Department of Health determined neglect was not substantiated. The resident was admitted to the hospital with gastrointestinal bleeding, urinary tract infection, sepsis, and septic shock. Although the resident's labs at the ED indicated his Coumadin levels were high, the resident's facility medical record indicated the facility had accurately administered and held the residents' medications as ordered. The facility record lacked any indication the resident had a change in condition prior to being transferred to the ED.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medication administration record, progress notes, staff communication notes, incident reports, vital signs, weight, and meal intake records. The investigator reviewed the resident's history and physical, emergency and hospital records, and photographs. The investigator observed other residents in the facility and interviewed another resident and family member.

The resident was admitted to the facility following a three-month hospitalization for a stroke. The resident's admission diagnoses included stroke, acute deep vein thrombosis (DVT) of upper extremity, stage 3 chronic kidney disease, hypertension, and chronic heart failure with ejection fraction of 20-25%. The resident had cognitive impairment, and was independent with toileting, dressing, and ambulation.

The resident's signed admission orders included Clopidogrel (Plavix) an antiplatelet medication used to prevent blood clots, prescribed for coronary artery disease. The orders also included Coumadin, an anticoagulant blood thinning medication used to prevent blood clots, prescribed for the resident's acute DVT. Both medications increased the resident's risk for bleeding.

The resident's provider communication notes indicated laboratory blood level monitoring was completed to ensure proper dosing for the resident's Coumadin medication. Seven days after admission the labs indicated the resident's coumadin level was high and ordered the facility to hold the Coumadin.

The residents medication administration record (MAR) indicated the resident's Coumadin medication was administered, and then held as ordered. The MAR indicated the resident had not received Coumadin for the last several days due to being on hold at the facility. No medication administration errors were identified.

A review of the resident's progress notes indicated he had recurring complaints of stomachaches, not feeling well, being cold, verbalized he was dying, and refused cares and meals beginning from the time of admission.

The resident's daily meal documentation indicated he generally ate at least two of the three meals offered each day and consumed 75-100% of the meals eaten. Weekly weight monitoring indicated the resident's weight had been stable since admission.

The resident incident reports indicated he had two falls at the facility with no injuries occurring including bruising. The second fall occurred the day the resident was transferred to the hospital when the resident slid out of bed.

The facility progress notes, and provider communication documentation indicated the resident had swelling in his eye area without bruising. The documentation indicated the swelling was noted prior to the resident's falls. The swelling was identified as edema related to positioning when the resident laid in his bed, and it was not the result of a fall. Staff encouraged the resident to change position, and the provider planned to follow up during rounds.

A review of a photograph of the resident's eye showed swelling as identified by the facility and reported to the resident's provider. No indication of bruising was able to be clearly identified as both eyes had similar coloring.

Interviews with facility staff indicated after the resident's second fall when the resident slid out of bed, he had no injuries and remained at baseline after the fall occurred. Staff stated the resident was out for lunch, and even went outside. Staff stated a couple hours later they went to get the resident up and he was not able to stand, 911 was called, and the resident was transferred for evaluation. Facility staff interviewed indicated the resident toileted himself, but indicated he had no bloody stools or signs of bleeding prior to being transferred.

The resident's facility vital sign documentation indicated the resident had no changes in temperature, pulse, respiratory rate, or oxygen saturation. The resident's systolic blood pressure from the time of admission ranged from 117 to 136, and diastolic from 60 to 70. The afternoon the resident had slid out of bed, his blood pressure reading was 96/40, lower than his normal, but he had no fever, and all other vitals were with in normal limits.

The ambulance report indicated the facility called to transport the resident to the emergency room for increased weakness and confusion, which was three hours after the resident had slid out of bed. The emergency medical team indicated the resident's blood pressure was low initially, so the blood pressure cuff was moved to the left arm with no other abnormalities found.

The hospital record indicated the resident was admitted with upper gastrointestinal bleeding, weakness, and UTI sepsis. A hospital progress note indicated despite efforts the resident's blood pressure continued to trend low from septic shock. The resident continued to deteriorate and died later that day.

A document titled record of death indicated the resident died from septic shock, with contributing factors of acute blood loss, anemia, and acute kidney injury.

When interviewed the resident's family member indicated the resident was able to call them independently using his own cell phone, and a family member visited regularly.

In conclusion, abuse and neglect were 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or

maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility identified the resident had increased weakness and confusion then called 911.

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

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
	34980	A. BUILDING: _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH ASSISTED LIVING	5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472

(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 Initial comments On September 22, 2022, the Minnesota Department of Health initiated an investigation of complaint HL349801241M, and HL349801997C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors ' 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 subd. 1, 2 and 3.	