Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349805343M
Compliance #: HL349809103C

Date Concluded: June 26, 2023

Name, Address, and County of Licensee Investigated:
Shiloh Assisted Living
5384 Country Care Lane
Pequot Lakes, MN 56472
Crow Wing County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 fell and injured his head, resulting in a brain bleed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident fell several times in the weeks leading up to his death and the facility failed to develop additional fall prevention interventions. However, when a fall with significant injury occurred the resident's primary care provider and hospice agency were updated appropriately, and the resident received timely medical care. It is unable to be determined if staff's failure to develop additional fall interventions would have prevented the resident's last fall with injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice and the primary care provider. The investigation included review of hospice records, emergency room records, and

facility records including progress notes, assessments, service plan, and incident reports. Also, the investigator observed resident cares in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included end stage liver disease, hepatic encephalopathy (an altered level of consciousness as a result of liver failure leading to confusion and forgetfulness), and chronic obstructive pulmonary disease (a progressive lung disease that can cause shortness of breath.) The resident's service plan included assistance with toileting, transferring, behavior management, and hourly safety checks. The resident's most recent assessment, completed two months prior to his death, identified the resident as at risk for falls. The assessment indicated the resident had sustained several falls and included fall interventions. The resident also received hospice services.

Hospice records indicated nurse and home health aide visits were increased to daily visits, due to a change in condition, a few days before the resident was sent to the hospital. At that time, the resident was noted to have labored breathing and difficulty swallowing medications. Around three weeks prior to the resident's death, the hospice physician documented the resident was experiencing more frequent hallucinations and delusions with two-to-three-day periods of unresponsiveness.

Facility records indicated the resident fell many times in the weeks leading up to his death, however incident reports were not completed after every fall. For the falls which were documented, the primary care provider (PCP) and hospice were updated within a reasonable timeframe. However, the last fifteen documented falls did not include any new or additional fall prevention interventions.

Hospital records indicated the resident was sent to the emergency room following a fall at the facility. The resident was diagnosed with a "closed head injury and left forehead abrasion/laceration." The emergency room physician wrote "was able to speak with the hospice nurse and we will go ahead with head CT knowing that if there is bleeding, patient would not be a candidate for any intervention…" The CT scan confirmed the resident had a right sided subarachnoid hemorrhage (brain bleed).

The resident discharged back to the facility after it was agreed no aggressive treatment would be done. The resident died two days later.

The resident's death record identified the cause of death as closed head trauma due to fall.

During an interview, a former facility registered nurse (RN) stated she implemented various interventions including the use of headphones, increased toileting times, frequent safety checks, and anticipation of needs, but the resident continued to fall. The former RN indicated she quit working at the facility approximately two months before the resident died. The former RN was not sure why the RN who replaced her did not implement new interventions.

During investigative interviews, multiple unlicensed personnel (ULP) stated the resident fell frequently and falls occurred on an almost daily basis. ULP stated the new RN did not ask them for feedback on fall interventions and did not talk to staff about new interventions after repeated falls. Multiple ULP said they would try to keep the resident busy and checked on him frequently, but sometimes he fell minutes after they last checked on him. ULP stated no matter what they seemed to do; they couldn't prevent the resident from falling.

During an interview, the resident's PCP stated the resident fell frequently but could also go weeks without any falls. The PCP stated the resident had encephalopathy due to liver failure (symptoms include difficulty thinking, confusion, forgetfulness, and poor judgment) and thought he could still do things on his own. The PCP stated staff notified her of falls and she had tried to brainstorm ideas to keep him from falling but didn't know what else they could have done. The PCP indicated staff would check on him and two minutes later, he'd be on the floor.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, 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 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

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 05/03/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL349805343M/ HL349809103C. On May 3, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 38 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL349809103C/#HL349805343M, tag identification __0730____.	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.	
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 1 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 2 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for one of one residents (R1). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included end stage liver disease, hepatic encephalopathy (an altered level of consciousness as a result of liver failure which can lead to confusion and forgetfulness), and chronic obstructive pulmonary disease (a progressive lung disease that can cause shortness of breath.) The resident admitted to the facility on March 14, 2019, and began receiving assisted living services under the licensee on August 1, 2021. The resident discharged on December 7, 2022, when he died at the facility. R1's record lacked the following required content:	0 730		

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0 730	Continued From page 3 -documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; -documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; -a discharge summary, including service termination notice and related documentation CHANGE OF CONDITION DOCUMENTATION Hospice records indicated the resident began to experience a change in condition on December 2, 2022, and nurse and home health aide visits would be increased to daily due to the change in condition. Hospice records noted the resident had labored breathing and had difficulty swallowing medications. A December 2, 2022, progress note completed by a facility nurse indicated "resident has shown decline in condition throughout the shift. Color appears dusky, SOB [short of breath] when lying down, when fed just pocketed the food, BP [blood pressure] varies...nonverbal with staff. Call placed to [hospice agency] and RN to come eval the resident within the hour." Progress notes indicated R1 had a fall with a head injury and was diagnosed with a brain bleed during an emergency room visit on December 5, 2022. Later that day, a facility nurse documented the resident had blood in his urine. The facility failed to reassess the resident after a change in condition was noted by hospice and facility staff on December 2, 2022 or when the resident returned from the emergency room with	0 730		

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0 730	Continued From page 4 a new diagnosis of a brain bleed on December 5, 2022. DOCUMENTATION OF INCIDENTS R1's record contained 15 incident reports for falls from October 3, 2022 through December 5, 2022. A December 1, 2022, incident report indicated the resident had "another three falls throughout the evening shift and was finally sent to the ER [emergency room]." The resident's record lacked any documentation of the December 1, 2022 ER visit or the three falls that had occurred earlier. A December 4, 2022, incident report indicated "resident has fallen several times in the last 24 hours." However, the most recent incident report documenting a fall prior to the December 4, 2022, report was entered on December 1, 2022. The resident's record lacked any documentation of the several falls from the past 24 hours. All 15 of the incident reports failed to document actions taken in response to the needs of the resident. The 15 incident reports all included the following under the section for follow up intervention and prevention plan, "Continue with hourly safety checks, staff to toilet resident every two hours, resident is on hospice at this time and has exhibited an increase in weakness. Will continue to monitor." DISCHARGE SUMMARY R1's December 7, 2022, discharge summary indicated the resident was at risk for falls but had no known falls in the last six months. The discharge summary further indicated the resident had not had any known emergency room visits in the last six months.	0 730		

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0 730	Continued From page 5 On May 3, 2023, at 11:30 a.m., executive director (ED)-C confirmed a reassessment should have been done after R1 returned from the emergency room with a newly diagnosed brain bleed. ED-C stated she was not sure why it was not completed. ED-C confirmed R1's discharge summary was not an accurate reflection of the resident's condition at the time of discharge and that he had been to the emergency room and had many falls. ED-C stated they had tried many more interventions that were not listed on the incident reports and confirmed different interventions should have been documented in the resident's incident reports. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		