Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350523366M
Compliance #: HL350525419C

Date Concluded: January 6, 2023

Name, Address, and County of Licensee Investigated:
Pelican Landing Senior Living
1325 Pelican Lane
Detroit Lakes, MN 56501
Becker County

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

Evaluator's Name: Barbara Axness, 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 neglected the resident when the resident left the secured memory care unit unattended. The resident fell while trying to open a window in an employee office, resulting in a fractured arm that required surgical repair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the incident occurred, it did not meet the definition of neglect. The resident's elopement and fall with injury were isolated incidents. Facility policies, procedures, and the resident's service plan were followed at the time of the incident. The resident was hospitalized for a right arm fracture and returned to the facility several days later. Upon completion of therapy, the resident's arm fracture healed, and the resident returned to her baseline health status.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident's hospital records, service

plan, assessments, progress notes, documentation of services, and care plan. Also, the investigator observed the secured memory care unit and the route the resident used to exit the unit.

The resident resided in an assisted living with dementia care secured memory care unit. The resident's diagnoses included dementia and anxiety. The resident's service plan included assistance with dressing, grooming, bathing, toileting, and medication administration. The resident's assessment indicated the resident had a history of exit seeking behaviors, especially when wanting to know her daughters' whereabouts. The resident also had a history of looking for her daughters in the evening, thinking she needed to go home.

The resident's progress notes indicated the resident was found in the late afternoon in an office outside of the secured memory care unit. The resident was lying on her right side with the window from the office on top of her. The resident's glasses were bent, and the resident complained of right arm pain. The resident was sent to the emergency room and diagnosed with a right arm fracture.

The resident's hospital records indicated the resident was admitted to the hospital for a surgical repair of her right arm. The resident was hospitalized for five days and discharged back to the facility with an arm sling and orders for her right arm to be non-weight bearing.

The resident's progress notes indicated she started physical and occupation therapy a few weeks following her return from the hospital when she was able to bear weight on her right arm. The resident returned to her baseline condition.

During investigative interviews, multiple staff members involved with the incident stated the afternoon the elopement and fall occurred, the resident had increased anxiety and was very focused on finding her daughters. The staff members stated the resident's granddaughter worked at the facility, and she was often able to help the resident relax since she is a familiar face. The staff members felt since the resident recognized that staff member (her granddaughter), she followed her to find her daughters. The staff said the door of the unit had a 10 second re-lock system and the resident must have gotten out the door after the other staff member went into the office and before it re-locked. However, once the resident got through one door, she was stuck in the vestibule area where the door required a key code to exit, and the other door required a button be pushed to open. The staff thought since the resident couldn't find anyone or a way to get out, the resident tried to get out by opening the window. The window was locked and could not fully open. Staff thought that as the resident pulled on the window, it came off the panel and the resident fell backwards.

During an interview, one staff member said right before the incident occurred, she assisted the resident to the kitchen and provided her with coffee and a snack. The resident seemed to calm down, so the staff member left the secure unit and walked back to the office. The staff member recalled that she even turned to look back to make sure the resident was still seated at the

table before she exited the locked unit. The staff member said she left the unit through the locked door, went through a small vestibule, and through another locked door to a nursing office to visit with another employee. After a few minutes they heard a faint sound but assumed it was someone in the bathroom next to the office. A short time later, they heard a loud crash and when they left the office, they found the resident on the floor with the window panel on top of her. They immediately called 911 to transfer the resident to the emergency room and informed the resident's family of the incident.

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:
(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, not able to interview due to dementia
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the elopement and fall to the Minnesota Adult Abuse Reporting Center (MAARC), initiated an internal investigation, and reviewed security camera footage. Staff were re-educated on making sure the door was securely closed after exiting. Maintenance adjusted the timing of the door close while still maintaining compliance with fire code. The resident was re-assessed upon her return from the hospital and additional services were added to her service plan.

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

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
	35052	A. BUILDING: _____ B. WING _____	C 12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN LANDING SENIOR LIVING	1325 PELICAN LANE DETROIT LAKES, MN 56501

(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 December 27, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL350525419C/#HL350523366M. 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.	