Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356607187M
Compliance #: HL356603705C

Date Concluded: September 27, 2023

Name, Address, and County of Licensee Investigated:
Carver Ridge Senior Living
920 6th Street West
Carver, MN 55315
Carver County

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

Evaluator's Name: Michele Larson, 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 they failed to ensure the resident was provided her required services and supervision according to the resident's assessed needs. The resident had five falls over the course of nine days with injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had three falls over two days and the facility implemented medication changes. Staff were aware of the resident's fall and high fall risk. The resident required staff assistance with walking and use of a walker. The fourth fall occurred three days later. Facility video footage showed the resident wandering the hall unattended for 45 minutes without her walker. Several staff were seen on the video footage observe the resident and failed to provide assistance. The resident subsequently fell backwards, hit her head causing a head bleed and pain. Due to the resident's hospice services, X-rays were not indicated

due to no surgical interventions, however hospice suspected a hip fracture that could have occurred from fall #4 or fall #5 (five days after fall #4).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's family member and hospice team. The investigator reviewed facility video and audio footage of the resident's fall. The investigation included review of the resident's external medical records, facility records, personnel files, and the facility's policies and procedures. In addition, the investigator observed resident cares during her onsite investigation.

The resident resided in an assisted living memory care unit. The resident admitted to hospice services one month prior to her fall due to her diagnosis of severe malnutrition and dementia. The resident's service plan included assistance with staff escorts to and from all destinations using her a walker. The resident's facility nurse assessment indicated the resident was alert and oriented to self only and was unable to retain, follow directions, or recall events. The resident was a fall risk and had severe chronic pain that affected her day-to-day activities. The resident's individual abuse plan (IAPP) indicated the resident made poor decisions but was aware of the risks even though she was unable to retain or follow directions. The resident was resistive to cares. Staff were to ensure the resident was safe before they briefly left the area to reattempt or try an alternate staff member.

The resident's facility record indicated the resident required cueing and redirection throughout the day. Interventions included observing and reporting changes in the resident's function and mobility to maintain her safety, in addition to reapproaching and reattempting cares, ensuring the resident was safe when she became resistive.

The resident's record indicated the resident sustained three falls three days prior to her fourth fall with head injury.

The resident's facility progress note indicated at 7:58 p.m., the resident had an unwitnessed fall in the hallway. Unlicensed personnel (ULP) found the resident lying on the floor bleeding from the back of her head. The resident appeared to be in pain.

Review of the facility video and audio footage indicated at 7:00 p.m. the resident walked unsteadily down the hallway without her walker or staff assistance. The resident wore slippers. The resident leaned on her right side as she walked. The resident wandered for 20 minutes then moved out of camera view. At 7:37 p.m., the resident reappeared on video footage. On the same footage, ULP-1 propelled a different resident in a wheelchair. Moments later, ULP-1 exited the other resident's room and walked towards the resident until he was within proximity, then turned entered another resident's room. ULP-1 did not stop to help the resident. At 7:43 p.m., ULP-2 walked out of a different resident's room, then stopped and turned to talk to another ULP. ULP-2 saw the resident as she walked unsteadily down the hallway without her walker or staff assistance but did offer any assistance. The resident appeared confused and

audibly whimpered and moaned. At 7:45 p.m., the resident fell backwards as she reached for the handrail mounted on the wall. The audio sound captured the resident's head hit the floor. The resident could be heard crying out "help me, help me." At 7:57 p.m. staff arrived to assist the resident as she laid on the hallway floor moaning. The resident raised her left hand to her head stating, "my head, it's so painful."

The video showed the resident wandered in the hall for over 45 minutes without her walker or staff assistance before she fell. The video showed several staff saw the resident and failed to intervene for her safety.

During an interview, a facility nurse stated leadership talked to the ULP about the resident's unsteadiness and falls during shift change. The facility nurse stated escort assistance required a staff member to stay with the resident or remain close by when they walked.

During an interview, the director of nursing (DON) stated they tried to educate the resident to use her walker, but the resident would get agitated because of her dementia. The DON stated an implementation they sometimes used was to remove the resident's walker from her room stating the resident would want to "get up" if she saw her walker in her room. The DON stated she watched footage of the resident's fall but did not view the 30 minutes that showed the resident walking unsteady and by herself. The DON stated she expected residents to use their assistive devices when walking. DON stated staff should have gone and helped the resident if she was unsteady.

During an interview, a hospice nurse stated she assessed the resident was unsteady on her feet and required stand-by assistance when she admitted the resident to hospice the month before her fall. The hospice nurse stated the resident's walker was stored away at an unknown location when she visited the resident, so the resident was unable to use it.

During an interview, the family member stated the resident needed staff to assist her when she walked but did not receive it.

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

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation and a post-fall huddle.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35660	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER RIDGE SENIOR LIVING	920 6TH STREET WEST CARVER, MN 55315

(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 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: #HL356608604C/#HL356605043M #HL356603705C/HL356607187M On July 20, 2023, 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 67 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL356608604C/#HL356605043M, tag identification 2360. The following correction orders are issued for #HL356603705C/HL356607187M, tag identification 2310, 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee staff failed to provide walking assistance for one of two residents (R2) with records reviewed. R2 required staff escort assistance with a walker and was a high fall risk. R2 wandered in the hall for 45 minutes without her walker. Several staff observed her alone and failed to provide assistance for safety. R2 fell, hit her head, had bleeding from her head and was in pain. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 record was reviewed. R2 admitted to the licensee's facility on June 16, 2021. R2's diagnoses included dementia without behavioral disturbance and malnutrition. R2's hospital record indicated on December 7, 2022, R2 fractured two vertebrae after she had an unwitnessed fall inside her apartment. R2's	02310		

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02310	Continued From page 2 family member (FM)-F indicated facility staff did not seemed trained in handling R2's refusal of cares due to her dementia. R2's initial hospice assessment dated April 3, 2023, at 10:00 a.m., indicated R2 was a high fall risk due to impaired functional mobility, unsafe walking, cognitive impairment, polypharmacy, pain, visual impairment, multiple diagnoses, and environmental hazards. Hospice registered nurse (RN)-I observed R2 appeared frail, unsteady on her feet, and required stand-by assistance. Safety measures included assistance with walking. R2 required a two-wheeled walker (2ww) for walking but refused to use it. R2's facility nurse assessment dated April 3, 2023, completed by director of nursing (DON)-C, indicated R2 was medically frail and used a 2ww when she walked. R2 was alert and oriented to self only. R2 had a history of falls. R2 had severe, chronic pain that affected her sleep and day-to-day activities. R2 resided in a locked memory care unit for increased supervision and care. R2 had impaired decision-making due to her dementia, and required cueing and redirection as needed (prn) throughout the day. Staff were to observe and report changes in R2's function and mobility to maintain her safety. Staff were to reapproach, reattempt cares, and ensure R2 was safe when she became resistive. R2's individual abuse prevention plan (IAPP) dated April 3, 2023, completed by DON-C, indicated R2 made poor decisions but was aware of the risks even though DON-C assessed R2 as being unable to retain or follow directions or recall events. R2 was resistive to cares. Staff were to ensure R2 was safe before they briefly left the area to reattempt or tried an alternate staff	02310		

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02310	Continued From page 3 member. R2's service plan dated May 1, 2023, indicated R2 received assistance with personal cares, medication management, behaviors, escorts, meals, laundry, and housekeeping. R2's service delivery record dated May 2023, indicated R2 was to receive staff escort assistance to and from all destinations using her assistive device as required. R2's record indicated between May 16, 2023 and May 17, 2023, R2 had three unwitnessed falls. R2's facility progress note dated May 20, 2023, at 8:00 p.m., indicated R2 had an unwitnessed fall while walking without her two-wheeled walker. Staff found R2 lying face up with blood coming from the back of her head. Review of the licensee's video and audio footage dated May 20, 2023, indicated at 7:00 p.m., R2 walked unsteadily down the hallway without her two-wheeled walker or staff assistance. R2 wore slippers. R2 leaned on her right side as she walked. R2 wandered for 20 minutes then moved out of camera view. At 7:37 p.m., R2 reappeared on video footage. On the same footage, unlicensed personnel (ULP)-L propelled a resident in a wheelchair. Moments later, ULP-L exited the resident's room and walked towards R2 until he was within proximity, then turned and entered another resident's room. ULP-L did not stop to help the resident. At 7:43, ULP-M walked out of a resident's room, then stopped and turned to talk to another ULP. ULP-M saw R2 as she walked unsteadily down the hallway without her walker or staff assistance but did offer any assistance. R2 appeared confused and audibly	02310		

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02310	Continued From page 4 whimpered and moaned. At 7:45 p.m., R2 fell backwards as she reached for the handrail mounted on the wall. The audio sound captured R2's head hit the floor. R2 said "help me, help me." At 7:57 p.m. staff arrived to assist R2 as she laid on the hallway floor moaning. R2 raised her left hand to her head stating, "my head, it's so painful." The facility video footage lacked evidence staff stopped to provide escort assistance or obtain her walker when they saw her wandering alone in the hallway for 45 minutes. In an email dated August 21, 2023, at 9:16 a.m., to DON-C and LPN-H, the investigator requested R2's fall assessment. In an email dated August 21, 2023, at 11:50 a.m., LPN-H sent R2's assessment dated April 3, 2023. LPN-H indicated R2's fall assessment was located on page 11. On page 11, in a section titled "Fall Risk," contained only one question, "Has the resident had any falls in the last three months?" DON-C entered the response "no." R2's fall assessment failed to assess R2's functional status that included her mobility, cognition, gait, strength, balance deficits, or assistive devices to determine her risk of falls. During an interview on August 8, 2023, at 10:30 a.m., DON-C stated R2 was always a fall risk. DON-C stated on May 17, 2023, they discontinued R2's anti-anxiety medication (lorazepam) as a fall intervention after R2 had two falls in one day. During an interview on August 9, 2023, at 10:45 a.m., ULP-E stated staff followed residents'	02310		

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02310	Continued From page 5 service plans to determine what services would be provided to residents. ULP-E stated although R2 was resistive to cares, she never had a problem with R2 stating she would leave and reattempt if R2 refused. ULP-E stated R2 intimidated a lot of the younger ULPs and made them scared of her, stating, "R2 probably wasn't getting the cares she should have on some shifts." During an interview on August 14, 2023, FM-F stated R2 required staff assistance when she walked but did not receive assistance. During an interview dated August 21, 2023, at 10:00 a.m., LPN-H stated escort assistance required a staff member to stay with the resident or remain close by when they walked, stating "in a perfect world somebody should be with them." LPN-H stated they discussed R2's falls and unsteadiness during shift change. LPN-H stated R2 became more unsteady on her feet after each fall. During an interview on August 30, 2023, at 4:30 p.m., hospice nurse LPN-J stated R2 was already a fall risk when she lived in the assisted living side of the facility. During her third interview on September 7, 2023, at 9:46 a.m., DON-C stated it was her expectation staff would be with R2, get her walker if they saw her walking alone, or obtain a wheelchair if she was very unsteady. DON-C stated an intervention they sometimes used was to not have R2's walker in her room because it instigated R2 to want to "get up." DON-C insisted R2's walker was in her room the night she fell, stating R2 did not use it. DON-C stated she expected staff to ensure residents had their assistive devices with	02310		

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02310	Continued From page 6 them, and if R2 appeared unsteady, then staff should have been with her. The licensee policy titled Service Plan, updated April 2023, indicated a service plan meant the written plan between a resident or the resident's designated representative and the home care licensee about the services that would be provided to the resident. TIME PERIOD TO CORRECT: Seven (7) days	02310		
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) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for R1's maltreatment, in connection with incidents which occurred at the facility. In addition, MDH issued a determination maltreatment occurred. The facility was responsible for R2's maltreatement in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	