

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL376331823M
Compliance #: HL376333497C

Date Concluded: October 5, 2022

Name, Address, and County of Licensee

Investigated:

Willows Landing Senior Living
9872 Hart Boulevard
Monticello, MN 55362
Wright County

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

Evaluator's Name: Jill Hagen, 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 they failed to provide supervision and protect the resident from an unknown alleged perpetrator (AP) to prevent serious injury to the resident. As a result, the resident hit her head on a door causing a brain bleed.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Staff found the resident on the floor in her room next to her bed bleeding from the left side of her head. Although the resident was not able to report to staff the circumstances surrounding the injury,

according to the resident's history of falls and location next to her bed, staff concluded the resident fell out of bed, hitting her head on the bedside table. There was no evidence an unknown individual injured the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's power of attorney. The investigation included review of the resident's medical record, emergency room record and hospital record, facility policies and procedures, staff schedules and education. In addition, the investigator observed the security of the memory care unit, access to the unit, layout of the memory care unit, and took pictures of the hallways and common areas of the memory care unit.

The resident resided in a secured assisted living memory care unit. The resident's diagnoses included delirium, diabetes, metabolic encephalopathy, (change in chemicals in the blood that cause personality changes), adult failure to thrive, depression and anxiety. The resident's service plan included staff assistance and/or cues with dressing, grooming, bathing, medication administration, incontinence care and toileting every two hours, visual checks eight times in an eight-hour shift, and meal preparation. The resident used a walker to assist with ambulation, required staff to escort to meals, and assessed a high risk for falls. The resident made her basic needs known to staff but required others for decision making. Interventions in place to prevent falls included therapy, specialized shoes for ambulation, a call pendant, and keeping frequently used items close to the resident.

The facility's memory care unit was in the shape of a "T" with the main dining room, common room, and nurse station directly inside the main secured door. After the common area, the unit consisted of two hallways of resident rooms.

A diagram of the resident's room indicated the head of the bed was against one wall with a nightstand on either side of the bed. The resident was found on the floor at the side of the bed with the resident's head near the nightstand and her feet toward the bottom of the bed.

The incident report indicated early one morning staff entered the resident's room to provide the resident her morning medications. The resident was on the left side of her bed on the floor in a pool of blood under her head. The resident had a laceration (cut) and large hematoma (bruise) on the left side of the face/head with a skin tear on the left forearm. Staff applied pressure to the open area and arranged for emergency services to transport the resident to a hospital for an evaluation.

The hospital record indicated the resident was diagnosed with an intraventricular hemorrhage (internal brain bleed) and transferred to a higher level of care at another hospital. The resident's family chose for the resident to receive comfort care and the resident passed away four weeks following the injury.

During an interview, unlicensed staff working at the time of the fall stated the resident was in bed during a wellness check about one-half to one hour before finding the resident on the floor. All doors to the memory care were secured and no visitors or other residents were near the resident's room during the incident.

During an interview, management stated there was no evidence of a stranger or other resident in the main hallway and common area of the unit during the incident. The resident had a history of falls despite interventions in place to help prevent falls. The resident could get out of bed independently and inconsistently used the call pendant to request staff assistance.

During an interview, a family member stated they had no concerns about the care provided to the resident at the facility.

The police investigation remained open.

Review of the resident's certificate of death indicated the resident's primary cause of death was complications of blunt force head injury with a subdural hematoma due to an unwitnessed fall.

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 of maltreatment 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: None identified.

Action taken by facility:

Following the incident, management educated staff to document timely and at the time of care.

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

Wright County Sheriff's Office

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37633 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 08/23/2022 |
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| NAME OF PROVIDER OR SUPPLIER WILLOWS LANDING SENIOR LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 9872 HART BLVD. MONTICELLO, MN 55362 |
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| (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 | <p>Initial Comments</p> <p>Initial comments On August 23, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL376333497C/#HL376331823M. No correction orders are issued.</p> | 0 000 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____