Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393122640M
Compliance #: HL393121964C

Date Concluded: October 17, 2024

Name, Address, and County of Licensee Investigated:
Personal Care Senior Living
14209 Inca Street NW
Andover, MN 55304
Anoka County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility and individual 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 a resident when they failed to ensure the resident received care, services, and supervision according to the resident's assessed needs. The resident fell and injured her head while walking unassisted. The resident bled for over 60 minutes before the resident was transported to a hospital where she received treatment for her head injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator (AP) and the facility were responsible for the neglect. The AP failed to follow the resident's care planned needs of providing stand-by assistance, a gait belt, and walker during ambulation. The resident fell and reopened a pre-existing closed head wound causing the resident unnecessary pain and suffering. In addition, facility staff failed to notify the on-call triage nurse a second time when the resident continued to profusely bleed from the head wound for 60 to 90 minutes. Also, the facility failed to have a system in place for the resident with hospice services, to be evaluated at a hospital following a head injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and hospice staff. The investigation included review of law enforcement reports, ambulance report, the resident's facility record, hospital records, hospice records, provider's records, facility incident reports, staff schedules, personnel files, and related policies and procedures. Also, the investigator observed residents and staff in the facility.

The resident resided in the assisted living side of an assisted living with dementia care facility. The resident's diagnoses included Lewy body dementia, Parkinson's disease, neurogenic orthostatic hypotension (a condition that causes light headedness when standing), and frequent falls. The resident received hospice services. The resident required assistance with transfers, toileting, activities of daily living, and safety. The resident had balance problems when standing, was able to walk independently inside her apartment only if she used her walker but required staff supervision, a gait belt, and stand-by assistance when walking in the facility. The resident was oriented to person, place, and time.

The resident's hospice record indicated the resident's fall interventions included a perimeter mattress to define the edges of the resident's bed, educating the resident to call for assistance before attempting to walk or transfer, stand-by assistance of one staff using a gait belt and a walker to ambulate outside the resident's apartment, and proper footwear.

The resident's provider note indicated the resident required ongoing, close monitoring due to increased severity and progression of the resident's diagnoses. The resident remained at high risk for falls, hospitalization, and mortality and required 24-hour care and monitoring.

A progress note indicated just before an overnight shift; the AP called the facility triage nurse to report they observed the resident walking outside her apartment pushing her wheelchair from behind. The AP left the resident unassisted to administer medications in another resident's apartment. Moments later, the AP found the resident on the common area floor, screaming, yelling, and refusing to let anyone touch or apply pressure to her bleeding head. The facility triage nurse contacted the on-call hospice nurse who advised staff to administer Tylenol for pain and lorazepam (antianxiety) medication. The triage nurse told staff the hospice nurse was on her way to the facility but was unsure of the arrival time.

The hospice note indicated the resident was actively bleeding when the on-call hospice nurse arrived at the facility. The hospice nurse documented the resident was "bleeding a lot." The resident wore a shower cap staff placed on the resident's head to the control bleeding. The hospice nurse observed multiple paper towels in a garbage can covered with blood. The hospice nurse called for emergency services. Law enforcement and emergency medical services arrived and measured the resident's wound as 1.5 inches x 1 inch gouged out area with a protruding flap of skin on the back of the resident's head. Facility staff were unable to provide information or details to law enforcement of what occurred or the exact time the resident fell.

The law enforcement report indicated they observed a chunk the size of a dollar coin missing from the back of the resident's head. The resident's wound consistently pulsated and spewed blood. Law enforcement attempted to speak to the resident, but staff stated the resident was normally confused and would not be able to answer law enforcement questions. Staff told law enforcement the resident bled for approximately 60-90 minutes before the hospice nurse arrived at the facility. Overnight staff stated they believed the resident may have fallen in the common area of the facility. A staff member stated the resident was attempting to clean her head wound when staff found her. Law enforcement asked staff why they did not call 911 when they observed the extent of the resident's injuries. Overnight staff repeatedly stated they did not know what happened since the resident's incident did not occur during their shift and stated they were waiting for the hospice nurse to arrive. The report indicated the hospice nurse was visibly upset when staff did not call 911 prior to her arrival due to the extent of the resident's injuries. The resident was transported to the hospital.

The resident's hospital record indicated the resident required six staples to close her head wound. Hours later the resident was discharged back to the facility.

When interviewed, the AP stated the resident always injured her head at the same place, stating it always reopened. The AP stated the resident pushed her wheelchair around the facility by herself stating, "she was very unstable." The AP stated the resident fell in the hallway sometime between 9:00 p.m. and 9:30 p.m. stating, "she was not stable." The AP stated another unlicensed staff assisted her with the resident after the fall by applying pressure and ice to the head wound. The AP stated the resident "bled so bad, I've never seen blood like that." The AP stated she left the facility at 10:45 p.m. before the hospice nurse arrived. No additional attempts were made to contact the triage nurse regarding the amount of bleeding from the resident's head injury.

When interviewed, a hospice nurse stated when she arrived at the facility, she observed the resident wearing a shower cap on her head, blood streaming down the resident's back stating, there was "blood all over the floor." The hospice nurse stated "I took one look at her and knew immediately I was calling 911. I was angry no one called 911." The hospice nurse stated she was grateful the resident did not die that night stating, "that was the gnarliest head wound I've ever seen."

When interviewed, the facility's on-call triage nurse stated the AP called her stating she saw the resident walk out of her room pushing her wheelchair from behind. The AP left the resident to administer medications to another resident. The triage nurse stated facility staff did not report the resident's bleeding was uncontrolled. The triage nurse stated because she was off-site, the triage nurse relied highly on what staff reported to her along with questions she would ask them. The triage nurse stated most facilities where she covers call after hours, have a head strike policy to direct on-call staff to arrange for an evaluation at a hospital for a resident receiving hospice services with any head injury. The triage nurse stated the facility did not have

a policy on residents with hospice services and no direction was provided by the facility to have a resident with hospice services automatically evaluated after a head injury.

During an interview, the facility nurse stated the resident loved to walk but was impulsive and unsafe to be left alone. The nurse stated the resident often walked around the facility pushing her wheelchair. The nurse stated she knew the resident "very well," stating "I've seen this wound reopen and reopen over and over and over and I don't feel the need to call 911 at that moment like she was having a life-threatening emergency over it."

When interviewed, the resident's family member stated the resident's Parkinson's disease and Lewy body dementia diminished the resident's ability to walk and stated the resident was not responsible for her actions. The family member stated, "She doesn't realize she can't walk by herself."

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. Unable to due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility sent the resident to the hospital for previous falls.

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
Anoka County Attorney
Andover City Attorney
Andover Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39312	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE SENIOR LIVING LLC	14209 INCA STREET NW ANDOVER, MN 55304

(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: #HL393121964C/#HL393122640M On August 21, 2024, 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 29 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL393121964C/#HL393122640M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. 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.	

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02310	Continued From page 1	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (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 failed to provide care in accordance with accepted healthcare standards for one of one resident (R1) reviewed. R1 fell after staff failed to provide the R1 stand-by assistance, a gait belt, and a walker when she walked in the community. As a result, R1 fell and opened a head wound. In addition, the licensee failed to ensure a facility registered nurse (RN), assessed, monitored, and developed and implemented interventions after R1 experienced several falls with injuries. 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: R1's medical record was reviewed. R1 was admitted to the licensee's assisted living facility on September 26, 2023. R1's diagnoses included Lewy body dementia, Parkinson's disease, neurogenic orthostatic hypotension (drop in blood	02310		

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02310	Continued From page 2 pressure upon standing), and frequent falls. R1 had a history of multiple falls prior to her admission to the facility. R1's service plan dated September 26, 2023, indicated R1 received daily assistance with toileting and transfers. R1's hospice record dated September 26, 2023, indicated R1 required staff assist of one for ambulation, transfers, bathing, dressing, toileting, and feeding. Fall interventions included a perimeter mattress to define the edges of R1's bed, educating R1 to call for staff assistance before attempting to transfer or ambulate, use of a gait belt with staff assist of one when transferring, and proper footwear. R1's hospice record dated September 27, 2023, directed staff to ambulate R1 with stand-by assistance, a gait belt, and walker. There was no evidence the licensee communicated to staff the ambulation assistance required for R1. R1's admission assessment dated October 10, 2023, indicated R1 was admitted to the licensee's facility for medication management, falls, assistance with activities of daily living (ADL's), and safety. R1 reported she fell multiple times and was assessed as a fall risk due to the following factors: Parkinson's disease, history of multiple falls, difficulty standing, transferring, and toileting assistance. Actions taken to reduce R1's fall risk included her scheduled services, call pendant within reach, and use of her walker when walking. R1 was able to walk independently inside her apartment only if she used her walker. R1's in-house provider notes dated December 7, 2023, indicated R1 required ongoing, close	02310		

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02310	Continued From page 3 monitoring due to increased the severity and progression of her diagnoses. R1 remained at high risk for falls, hospitalization, mortality, and required 24-hour care and monitoring. R1's fall incident report dated December 15, 2023, at 3:20 p.m., indicated R1 fell while attempting to toilet herself. R1 told staff she stood up, fell backwards, and struck her head on the bathroom floor sustaining a deep cut (laceration) to the back of her head. The facility called 911 who transported R1 to the hospital. R1 required several staples to close up her head wound. R1 was discharged back to the facility. R1's progress note listed "ambulating without assistance," as an environmental concern. R1 was discharged back to the facility. R1's record lacked documentation a facility RN assessed R1 after her incident or implemented fall interventions to prevent future falls. R1's progress note dated December 16, 2023, at 4:01 p.m., indicated R1 had an unwitnessed fall while self-transferring from her wheelchair to her bed. R1's hospice team and provider were notified. Three hours later, at 7:48 p.m., R1 fell and hit the back of her head on the medication cart while ambulating unassisted in the hallway outside of her apartment. R1's stapled head wound reopened and bled. Facility staff arranged for R1 to be transported to the hospital. RN-H documented, "Resident (R1) ambulating without assistance," as a causative factor. R1's hospital record dated December 16, 2024, at 8:47 p.m., indicated R1's head wound was stapled. R1 was unable to recall the incident but thought she may have fainted. R1's hospital provider indicated, "Unfortunately, it is a very	02310		

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02310	Continued From page 4 difficult wound to repair given the repeat trauma and very friable (irritated) tissue over the defect in addition to the underlying hematoma." R1 was discharged back to the facility on December 17, 2024, at 3:20 a.m. R1's record lacked documentation a facility RN assessed R1 after her incident or implemented fall interventions to prevent future falls. R1's incident report dated December 17, 2023, at 4:00 a.m., indicated R1 fell and struck her head on her bathroom floor causing the stapled head wound to reopen and bleed. A staff member documented, "R1 is forgetful that she cannot walk." Actions to prevent future falls included, keep R1 close to staff. R1's record lacked documentation a facility RN assessed R1 after her incident or implemented fall interventions to prevent future falls. R1's 90 day dated January 2, 2024 assessment directed staff to ambulate R1 with stand-by assistance of one with a walker. The licensee's assessment and service plan did not direct staff to utilize a gait belt with ambulation even though the hospice assessment dated September 27, 2023, directed staff to assist the R1 with ambulation outside of her apartment with stand-by assistance of one staff with gait belt and walker. R1's progress note dated March 5, 2024, at 10:20 p.m., and documented by facility triage nurse RN-F, indicated facility staff reported R1 walked out of her apartment pushing her wheelchair from behind. The staff member left R1 unassisted to administer medications in another resident's apartment. Moments later the staff member found	02310		

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02310	Continued From page 5 R1 on the floor, screaming and yelling, refusing to let anyone touch her or apply pressure to her bleeding head wound. RN-F contacted the on-call hospice nurse RN-D who advised staff to administer Tylenol for pain and lorazepam (antianxiety) medication. RN-F told facility staff RN-D was on her way to the facility but was unsure of her arrival time. R1's family was updated. R1's law enforcement report dated March 5, 2024, at 11:05 p.m., indicated law enforcement observed a chunk the size of a dollar coin missing from the back of R1's head. R1's wound consistently pulsated and spewed blood. Law enforcement attempted to speak to R1 but staff stated R1 was confused and would not be able to answer their questions. Staff told law enforcement R1 bled for approximately 60-90 minutes before RN-D arrived. Law enforcement asked staff why they did not call 911 when they realized the extent of R1's injuries. Staff stated since R1 was on hospice care and the incident did not occur during their shift, and not knowing what happened to R1, they did not call 911. Staff believed R1 may have fallen in the common area of the facility but were unsure. Unlicensed personnel (ULP)-A stated R 1 was trying to clean her own bloody head when ULP-A found her. The report indicated RN-D was visibly upset staff did not call 911 due to the extent of R1's injuries. R1 was transported to the hospital. R1's hospital record dated March 5, 2024, at 11:42 p.m., indicated R1 required six staples to close her head wound. On March 6, 2024, at 2:35 a.m., R1 was discharged back to the facility. R1's hospice note dated March 6, 2024, at 10:48 p.m., documented by RN-D, indicated R1 was	02310		

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02310	Continued From page 6 actively bleeding when RN-D arrived at the facility. RN-D indicated R1 was "bleeding a lot." R1 wore a shower cap staff placed earlier on her head to control bleeding. RN-D observed multiple paper towels in a garbage can covered with blood. RN-D contacted 911 and when the emergency medical services (EMS) arrived, they measured R1's wound as 1.5" x 1" gouged out area with a protruding flap of skin on the back of her head. Facility staff were unable to provide information or details of what occurred or the exact time R1 fell. R1's record lacked documentation a facility RN assessed R1 after her incident or implemented fall interventions to prevent future falls. During an interview on August 26, 2023, at 9:00 a.m., family member (FM)-C stated R1's Parkinson's disease and Lewy body dementia diminished R1's ability to walk and stated R1 was not responsible for her actions. FM-C stated, "R1 does not realize she was unable to walk by herself." During an interview on August 26, 2024, at 12:05 p.m., RN-D stated when she arrived at the licensee, following R1's fall on March 5, 2024, R1 wore a shower cap with blood streaming down her back stating, there was "blood all over the floor." RN-D stated "I took one look at her and I knew immediately I was calling 911. I was angry no one called 911." RN-D stated she was grateful R1 did not die that night stating, "that was the gnarliest head wound I have ever seen." During an interview on August 28, 2024, at 9:00 a.m., ULP-G stated R1 always injured the same place on her head, stating it always reopened. ULP-G stated R1 would push her wheelchair and	02310		

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02310	Continued From page 7 move around the facility by herself stating, "She was very unstable." ULP-G stated R1 fell in the hallway sometime between 9:00 p.m. and 9:30 p.m. stating, "she was not stable. She bled so bad. I've never seen blood like that." ULP-G stated at 10:45 p.m. she left the facility before RN-D arrived stating she saw a "cop" in the parking lot as she left. ULP-G stated she did not stay at the facility because she needed to go home and take care of her kids. ULP-G stated the facility needed more staff in the facility during the overnight shift stating it was too much to have only two staff scheduled during overnight shifts. During an interview on September 4, 2024, at 11:00 a.m., RN-H stated R1 loved to walk but was impulsive and unsafe to be left alone. RN-H stated the resident would be seen walking, pushing her wheelchair in the facility. RN-H stated fall incident reports were completed for all resident falls. RN-H stated she knew R1 "very well," stating "I've seen this wound reopen and reopen over and over and over and I don't feel the need to call 911 at that moment like she was having a life-threatening emergency over it." When the investigator asked RN-H why she never performed a change-in-condition assessment on R1, RN-H stated, "Yes she fell. She had a history of falls and it was the same wound; it wasn't a new wound, so really no, there was no change." RN-H stated although there was no documentation she completed an assessment she "obviously" assessed R1. RN-H stated due to time that passed since R1's fall, she could not recall if she increased staff due to the number of times R1 reopened her head wound stating, there were "a lot of changes." The licensee policy titled Reporting, Documenting, and Reviewing Incidents Involving	02310		

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02310	Continued From page 8 Residents, updated July 2023, indicated licensed staff would complete an electronic incident report involving resident incidents that included written or verbal data from unlicensed personnel and the resident or any witnesses's to the incident. The RN would document details of the resident and their assessment, including any follow-up actions taken. TIME PERIOD TO CORRECT: Twenty-one (21) 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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, 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.	