Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL253233224M
Compliance #: HL253235261C

Date Concluded: December 8, 2022

Name, Address, and County of Licensee Investigated:
LuAnn's Place LLC
6660 West 175th Avenue
Eden Prairie, MN
Hennepin County

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

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Inconclusive

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 a resident when the facility failed to have the registered nurse assess the resident when the resident became increasingly unsteady and had trouble speaking.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility failed to have a registered nurse assess the resident when she displayed changes in behavior and steadiness, however, it is unknown if a registered nurse assessment would have improved the resident's outcome or change actions taken regarding the resident's decline in health.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's medical provider. The investigation included review of hospital medical records, facility medical records, personnel information, policies, and procedures. Also, the investigator observed staff members providing care to residents.

The resident resided in an assisted living facility with diagnoses including Alzheimer's disease. The resident's service plan included assistance with dressing, grooming, safety checks, vital sign monitoring, and medication assistance. The resident's initial registered nurse assessment indicated the resident did not have behaviors that required intervention, was independent with toileting and did not wear briefs or pads, was independent with transfers and mobility, and had experienced four falls without injury in the prior six months. There were no further registered nurse assessments in the resident's chart.

Review of the resident's facility medical record indicated on the first day the resident was admitted to the facility, the resident interacted with other residents by playing card games and was able to walk around the house and became very confused.

Notes from the second and third day indicated the resident felt dizzy and at times needed stand-by-assistance.

Notes from the fourth, fifth, and sixth day indicated the resident was confused.

Notes from day seven indicated the resident had a video check-in with the provider during the day and in the evening, "was losing her footing a lot", pacing, and trying to get into other resident rooms.

Notes from the nineth and tenth day indicated the resident was wandering into other residents' rooms, was anxious, and had as needed anxiety medication administered.
Additional notes from day ten indicated a staff member noted the resident was "very wobbly and unsteady" and was shuffling when she walked.

Notes from day twelve following admission indicated the resident was unsteady and was found sitting at the end of the hallway with a handful of fecal matter which she threw at a staff member. The resident cursed at the staff member who assisted in cleaning her up and staff needed to, "use a walker to give her a ride to her room," after bathing.

Day thirteen following admission the resident notes indicated the resident was in her room much of the day and in the evening, she was found sitting on the floor of her room with fecal matter smeared on the floor, bedding, and chair of her room. Staff members indicated the resident was "just dead weight" when they tried to get her up off the floor.

Day fourteen the residents' notes indicated the resident was lethargic and slept most of the day and was incontinent of urine while asleep.

Notes fifteen days after admission to the facility indicated the resident was laying on the floor, appearing comfortable. Later that day the resident was transported to the hospital.

Review of medical provider documentation indicated the facility was in correspondence with the provider on day nine of the fifteen days the resident was at the facility.

Review of the resident's hospital record indicated the resident had altered mental status, right leg pain, and an internal bleed outside of the brain likely related to trauma to the head. The hospital doctors indicated the resident's brain bleed was unlikely to fully explain her altered mental status and attributed the condition change to multiple factors including dementia, delirium, change in environment, and starting an as needed medication for anxiety. The providers were unable to determine when the resident would have sustained an injury causing the internal bleed outside the brain. The resident also underwent imaging of her leg for pain and no injuries were noted.

Review of facility policy indicated a registered nurse would complete a comprehensive nursing assessment when there is a change in a resident's condition.

When interviewed the medical provider stated she saw the resident after admission to the facility during a video visit but didn't see the resident in person or have any further video visits while the resident was at the facility. The medical provider stated she was in frequent communication with the facility regarding the resident and family of the resident.

During in interview, a nurse stated the resident was transitioning at the facility and staff were learning about her. The nurse stated there were times the resident could walk and other times that she could not or did not want to walk and that none of the staff noted the resident experiencing a fall. The nurse stated the facility was in contact with the provider regarding resident concerns.

During an interview, an unlicensed personnel member stated when the resident admitted to the facility, she was quiet and able to walk on her own. The unlicensed personnel member stated staff members were in contact with her regarding the resident and it seemed that the resident's moods would go up and down. The unlicensed personnel member also stated the facility was in contact with the provider rather than the registered nurse and the provider did not seem to have concerns regarding the resident's change in ability to walk.

During an interview with the resident's family member, she stated the resident lived alone and was independent with self-care and walking prior to being admitted to the facility. The family member stated she saw the resident the day before she went to the hospital and stated the residents behavior was unrecognizable. The family member stated the resident was speaking gibberish, was wearing an incontinent brief, and acting skittish.

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, resident 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
	25323	A. BUILDING: _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUANN'S PLACE LLC	6660 WEST 175TH AVENUE EDEN PRAIRIE, MN 55346

(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 ******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: #HL253235261C/#HL253233224M On October 12, 2022, 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 five residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL253235261C/#HL253233224M, tag identification 1620.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have a registered nurse reassess one of one resident (R1) reviewed for change of condition when R1 had a change in behavior, continence, and ability to ambulate. R1's initial RN assessment indicated R1 was independent with ambulation, continent of urine and bowel, and did not have any known behaviors. During the first two weeks at the facility, R1 became increasingly unsteady, had instances of incontinence, and began to have behaviors. R1 remained at the facility for approximately two weeks until she was transferred to the hospital for	01620		

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01620	Continued From page 2 further evaluation and treatment. 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) 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). Findings include: R1's medical record indicated the resident was admitted April 20, 2022, due to diagnoses that included Alzheimer's disease. R1's service plan dated April 18, 2022, indicated R1 received services from the facility including dressing, grooming, skin monitoring, nail care, safety checks, monthly vital sign monitoring, and medication assistance. R1's pre-admission nursing assessment dated April 7, 2022, indicated R1 was independent with bed mobility and transferring and R1 needed occasional supervision/standby help and had a history of four falls in the past six months. The pre-admission assessment indicated R1 did not need help with toileting and did not wear briefs or pads. The pre-admission assessment indicated R1 had no behaviors that required intervention and that she had a history of anxiety. R1's service notes dated April 20, 2022, indicated the resident socialized with staff and other residents after her arrival to the facility and at 5:00 P.M. became confused and wandered into other residents' rooms and was able to be calmed after a phone call with her daughter.	01620		

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01620	Continued From page 3 R1's service notes dated April 21, 2022, indicated the resident had a "pleasant demeanor" and at 5:00 P.M. began to wander around the house and staff followed R1 due to R1 reporting feeling dizzy. R1's service note dated April 22, 2022, indicated the resident was "pretty independent" with showering and had a standby assist due to reporting feeling "wobbly" or "dizzy" at times. R1's service notes dated April 26, 2022, indicated in the evening R1 was continually pacing and "losing her footing a lot". R1's service notes dated May 1, 2022, indicated R1 was incontinent of bowel and after breakfast time a staff member found R1 sitting at the end of the hallway with a handful of fecal matter which R1 threw at the staff member. The note indicated R1 cursed at staff members that were trying to clean her up and that R1 was very unsteady. R1's service notes dated May 2, 2022, indicated R1 was found sitting on the floor of her room with fecal matter smeared on the floor, bedding, and chair. Bodily fluid was also noted in the garbage can. The staff member noted R1 was "dead weight" when the staff member tried to get her up and a wheelchair needed to be used to get R1 to the shower. R1's service notes dated May 3, 2022, indicated R1 was lethargic and incontinent of urine while asleep. R1's service notes dated May 4, 2022, indicated R1 was laying on the floor and appeared comfortable. Later that day R1 transported to the hospital.	01620		

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01620	Continued From page 4 An electronic communication to R1's medical provider on April 28, 2022, at 9:37 A.M. from the licensed assisted living director stated R1 "is displaying increased behaviors that are very upsetting to other residents." An electronic communication to R1's medical provider on May 3, 2022, at 6:52 P.M. from the licensed assisted living director stated R1 "is not the same woman who moved in. Very week and unstable." During an interview on October 28, 2022, at 3:49 P.M., the licensed practical nurse (LPN)- A stated resident behavior changes warrant escalation and a doctor would be contacted about concerns. LPN-A stated she worked at the facility for seven years and she does not believe she has ever contacted the facility registered nurse with a resident concern but contacted the providers and emergency services for non-emergent lifts. During an interview on November 2, 2022, at 9:01 A.M., the licensed assisted living director (LALD)-B stated staff reached out to her regarding concerns about R1 and rather than contact the registered nurse about concerns or changes, the facility was in contact with the medical provider. Policy titled "Initial and On-Going Nursing Assessment of Residents, dated November 1, 2021, indicated a registered nurse will complete comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: pre-admission assessment, 14-day assessment, ongoing assessment, and change in resident condition.	01620		

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01620	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) Days	01620		