DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30347001M
Compliance #: HL30347002C

Date Concluded: August 22, 2022

Name, Address, and County of Licensee Investigated:
Falls Landing Assisted Living
1101 N. Hiawatha Ave.
Pipestone, MN 56164
Pipestone County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jana Wegener, 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 alleged perpetrator (AP) neglected the resident when the AP failed to provide safety checks during the night. The resident fell and was not found until seven and a half hours later and was transferred to the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident reported she had fallen on the floor one evening and laid there for seven and a half hours before receiving staff assistance. However, the AP documented checking on the resident

during the night. Due to conflicting information, it could not be determined if the resident had been checked on according to the plan of care.

The investigator conducted interviews with facility staff members, including administrative, nursing, and unlicensed staff. The investigator interviewed multiple other residents in the facility and contacted the resident's family member. The investigation included review of emergency room records, facility progress notes, resident and facility safety rounding documentation, staff training records, and facility policies and procedures.

The resident resided in an assisted living facility with diagnoses including chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), congestive heart failure, and diabetes.

The resident's medical record indicated she was alert, orientated, and able to make her needs known. The resident was at risk for falls and had a history of falling. The resident was independent with transferring and ambulation but required staff monitoring, verbal prompts, and assistance with transferring and ambulation as needed. The service agreement indicated the resident utilized "I'm O.K. bed checks" which were completed at 10:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m.

The facility incident report indicated at 4:41 a.m. another resident had put on their call light and told the AP they heard someone calling for help. The AP found the resident on the floor near her recliner with her call light was out of reach. The report indicated the resident told the AP she had just removed her oxygen and was going to the bathroom when she fell. The resident was transferred by ambulance to the emergency department for evaluation.

The ambulance report indicated the resident was having low back pain from laying on the floor for more than seven hours after falling.

The hospital emergency room record indicated the resident reported she had fallen on the floor at 9:00 p.m. and laid on the floor all night long until staff found her over seven hours later.

The resident's facility treatment administration record (TAR) indicated staff documented the resident was checked on by staff the night of the incident at 10:13 p.m., 12:08 a.m., 2:10 a.m., 3:54 a.m., and 4:50 a.m.

The TAR documentation of all residents who resided in the facility was reviewed and indicated the AP provided rounds for all residents and documented completion of the task at the same time. As a result, documentation of checks completed by the AP were not completed at the point of care for the resident(s) and did not provide accurate documentation of services provided. The AP documented in a progress note the resident was observed in her recliner chair after the resident reported she had fallen. The AP documented checking on the resident, and all residents in the facility at the same time.

The resident's progress note completed by the AP on the night of the incident indicated the resident was observed in her recliner at 10:00 p.m. This was approximately one hour after the resident reported she had fallen on the floor.

When interviewed the resident's family member stated the resident had been consistent in the reporting of the fall regarding the times she fell and indicating she laid on the floor all night.

When interviewed three other residents who lived in the facility stated they turned the call light on when they needed staff assistance and staff assisted them as needed. The residents also stated they were checked on by staff during the night and provided assistance as needed.

During interview the AP stated she had completed checks on the resident through the night. The AP indicated she routinely documented the resident checks at the end of her shift unless there was something different or unusual to report. The AP indicated she did not know the exact times when she had checked on the resident.

In conclusion, it was inconclusive whether neglect occurred.

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:
(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, Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the resident's report of not being checked on and being left on the floor after falling.

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.

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
	30347	A. BUILDING: _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(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 July 21, 2022, the Minnesota Department of Health initiated an investigation of complaint HL30347001M, and HL30347002C. No correction orders are issued.	0 000		