Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL239867524M
Compliance #: HL239864075C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:
Elderwood of Hinckley
710 Spring Lane,
Hinckley, MN, 55037
Pine County

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

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Not Substantiated

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):
Facility staff neglected a resident when staff failed to ensure the resident received oxygen as prescribed for two days causing the resident to become unresponsive and require hospitalization for low oxygen levels. In addition, staff failed to ensure the resident received her prescribed medications; failed to ensure the resident received physical and occupational therapy as prescribed; and failed to provide appropriate supervision to prevent the resident from eloping from the facility.

Unknown facility staff abused the resident when the staff person grabbed the resident's arm and yelled at her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff noticed a change in the resident's condition, assessed the resident, and arranged for the resident to be evaluated at a hospital. The resident's medication order included Methadone

(opioid narcotic pain medication) three times a day. Although there was a delay with the pharmacy obtaining the medication, facility staff provided another as needed (Oxycodone) opioid pain medication for the resident. The resident's record indicated the resident received physical and occupational therapy as ordered. There was no evidence the resident eloped from the facility.

The Minnesota Department of Health determined abuse was not substantiated. There was no evidence an unknown alleged perpetrator yelled and/or grabbed the arm of the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's care coordinator and family member. The investigation included review of the resident's medical record, hospital records, medication records, facility narcotic count record, facility schedules, death certificate, incident reports, and policies and procedures. Also, the investigator made an onsite visit to the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included spasmodic torticollis (a painful condition where the neck muscles contract involuntarily, causing the head to twist or turn to one side), schizoaffective disorder, and chronic obstructive pulmonary disease (COPD). The resident's service plan included assistance with medication management and oxygen management. The resident's assessment indicated the resident required continuous oxygen, had difficulty with eating and swallowing due to spasmodic torticollis, used a wheeled walker for walking, and had chronic pain. The resident's assessment indicated the resident was alert and oriented and made her own decisions.

The residents care plan directed staff to check the resident's oxygen saturation daily and to report to a nurse an oxygen saturation lower than 90%.

A progress note indicated one day over a two-hour period, the resident continued to shut off her oxygen concentrator and liquid oxygen tank despite staff checking on the resident every 10 to 15 minutes and providing the oxygen. Early the same afternoon after completing the resident's nebulizer (breathing) treatment the resident's oxygen saturation was low at 71%, the resident was confused, and short of breath. Facility staff arranged for the resident to be evaluated at a hospital.

The hospital record indicated the resident arrived at the emergency room with confusion, rapid heart rate, and rapid breathing. The resident required eight liters of oxygen and the resident's laboratory values indicated oxygen saturation was 75% (normal range 95-100%). The resident was transferred to a hospital that provided a higher level and care. The resident's diagnoses included COPD exacerbation (a sudden worsening of respiratory symptoms.) Nine days later the resident passed away.

During an interview, unlicensed staff member (ULP) stated the day the resident was sent to the hospital the facility staff found the resident's concentrator shut off three separate times over the course of 20 minutes. Leadership was notified, and the resident was sent to the hospital because her oxygen saturation was low.

During an interview, another ULP stated the day the resident was sent to the hospital, the resident kept shutting off her oxygen. The resident was drooling and pale. The ULP stated staff checked on the resident frequently.

During an interview, the nurse stated the resident was at risk for pneumonia because of the anatomy of the resident's neck and the way her head tipped off to one side. The resident used oxygen continuously and had both an oxygen concentrator (took air from your surroundings, extract oxygen and filter it into purified oxygen for you to breathe) and portable oxygen tanks. The nurse stated the resident missed two days of the Methadone because the pharmacy needed a new prescription from the physician. The nurse also stated the resident worked with an outside therapy agency for physical and occupational therapy. The nurse stated the resident did not report concerns of abuse.

During an interview, leadership stated the resident was alert and oriented. The resident had a history of adjusting the oxygen concentrator on her own. The resident was not a wander risk and liked to be outside by the garden. Leadership stated they routinely checked with the resident and no concerns with medication management, wandering, or abuse was reported.

Review of the resident's certificate of death indicated the resident passed away due to respiratory failure due to COPD.

In conclusion, the Minnesota Department of Health determined abuse and neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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

Action taken by facility:
The resident was sent to the hospital.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	C 09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(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 On September 20, 2023, the Minnesota Department of Health initiated an investigation of complaint HL239867524M/ HL239864075C and HL239868285M/HL239865464C . No correction orders are issued.	0 000		