Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282046964M
Compliance #: HL282043245C

Date Concluded: December 22, 2023

Name, Address, and County of Licensee Investigated:

Hometown Senior Living
3610 Mt Vernon Ct
Woodbury MN
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier, 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):
The facility neglected a resident when he aspirated and deteriorated with no intervention until the resident passed away. Then the facility could not give the emergency medical services (EMS) the residents do not resuscitate (DNR) directive, so EMS started resuscitation until family arrived.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident did pass away from aspiration, the assisted living staff stayed with the resident and contact the nurse appropriately as trained. While it was true the facility did not have the documentation for the resident's DNR status and the resident received resuscitation, these efforts were discontinued when family clarified the resident's advance directives.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The

investigation included review of facility records, facility policies and employee records, the resident records, hospital records and coroner's report. Also, the investigator observed staff interactions with other staff, residents, and visitors.

The resident resided in an assisted living facility. The resident's diagnoses included multiple system atrophy (a condition with gradual damage to nerve cells in the brain which controls several basic functions such as breathing, digestion and bladder control), heart failure and dementia. The resident's service plan included assistance with bathing, dressing, toileting, incontinence cares, transferring, medications, repositioning, and queuing for eating. The resident's assessment indicated the resident was weight-bearing but could not walk on his own and had occasional disorientation with mild to moderate cognitive impairment. The care plan also indicated the resident would take some pills crushed in pudding or apple sauce and some pills he would take whole without difficulty.

The following events were captured by a video and audio recording.

The recording begins with the resident was sitting in his chair in his room and wanted to rest in bed. Two unlicensed personnel (ULP)'s assisted the resident into bed using a sit to stand device. The resident was positioned with the head of the bed up and his call pendent in place and his tv remote control was in his hand.

Sometime later, a ULP gave the resident some of his medication crushed in pudding. Then a few minutes later the ULP gave the resident some pills to swallow. The resident had a glass of lemonade which he sipped from and the ULP left the room. A brief time later the resident yelled for help, began coughing, and an audible gurgling occurred while he called for help again.

Two ULP's entered his room and offered to reposition the resident, gave him some tissue to spit into, which the resident took, and told the resident to cough, which he did. The resident continued to speak with the ULPs, and they continued to try repositioning the resident, offer sips of fluids, and encourage coughing. The resident stated his chest hurt and burned.

One of the ULPs left but returned and the video shows her in discussion with the registered nurse. The video showed the ULP check the resident's temperature while on the phone with the RN. The video showed that at least one ULP stayed by the resident's side and the resident continued to deteriorate. The video showed from the time the resident called for help and the ULP is seen on the phone with the nurse approximately 15 minutes elapsed.

While not shown on the video, the investigation determined the RN also called the resident's family and then activated 911.

EMS arrived and started resuscitation initially because the facility staff members could not locate his paperwork regarding health care directives. Once a family member arrived who was

able to confirm the resident's health care directive for do not resuscitate (DNR) EMS discontinued treatment.

During an interview, facility leadership reported that the resident was well-known and liked. Facility leadership respected the family's wishes to have notes around the resident's room about how to position the resident and what the resident likes and dislikes. This was done to remind staff of how to care for the resident. Leadership also stated they do not know the residents DNR paperwork could not be found on the night of the incident but acknowledged they have since implemented a folder system to holds all resident's resuscitation wishes in the event of an emergency.

During an interview, the registered nurse stated she trained the ULP's to this resident's specific needs and requests, which included keeping the head of the bed up at 90 degrees. The RN stated there were signs all over the resident's room on how to care for the resident and all the ULP's were trained on these items. The nurse also stated that the ULP's should call the RN when there are any concerns about the resident. The RN stated the ULP's did what they were trained to do for this resident. The RN also stated that the resident had no prior episode of choking or aspirating.

During an interview, the ULP reported that she did not think the resident was choking on anything because he was talking and coughing and spiting stuff out of his mouth. She realized he was not doing well when he stopped talking to them and his breathing was different. The ULP stated EMS got there shortly after this. The ULP stayed with the resident.

During an interview, a family member stated that the resident had many swallowing evaluations that showed the resident did not have swallowing issues. The family member stated the family helped many times with the resident by spending the day taking care of the resident, especially if there was not enough staff on any given day. The family member also acknowledged the signs all over the resident room, directing staff on how to provide care for the resident.

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 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.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reviewed the incident and implemented an emergency folder that holds all resident's resuscitation directives. This folder in kept in a central location and staff are responsible for knowing it is location. The registered nurse is responsible for ensuring each residents information is up-to-date and in the book.

Action taken by the Minnesota Department of Health:
No further action 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
	28204	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING - WEDGEWOOD	3610 MOUNT VERNON COURT WOODBURY, MN 55129

(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 November 15, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL282043245C/#HL282046964M. No correction orders are issued.	0 000		