Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL297192121M
Compliance #: HL297193768C

Date Concluded: March 17, 2023

Name, Address, and County of Licensee Investigated:
The Legacy of St. Anthony
2540 Kenzie Terrace
St. Anthony, MN, 55418
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 the resident when the resident fell, sustained an abdominal injury, and passed away the same day.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had an unwitnessed fall, fell into a dresser, hit her abdomen, and sustained a spleen laceration. The resident passed away the same day. Prior to the resident's fall the resident had a decline in health and admitted to hospice services. Although the facility failed to conduct a change of condition assessment after the resident admitted to hospice services, the resident did not have a pattern of falls during her health decline and knew how to use her call pendent. During interviews, staff and the resident's family member stated the resident was independent with activities of daily living. The resident received services according to the service plan.

The investigator conducted interviews with facility staff members, including nursing staff, unlicensed staff, and the resident's family. The investigation included review of the resident's medical record, service delivery records, emergency room records, hospice records, death record, incident reports, and policy procedures related to nursing assessments, changes in condition, falls, and maltreatment. Also, the investigator observed the facility including common areas.

The resident resided in an assisted living facility. The resident's diagnoses included lung disease, congestive heart failure, and enlarged heart. The resident's service plan included assistance with medication administration, compression stocking application, and showers. The resident's assessment indicated the resident was alert, oriented, and used the call system independently. The same assessment indicated the resident was at risk for falls and fell occasionally.

The resident's incident report and internal investigation indicated one day at 6:30 a.m., the resident used her call pendent, and staff responded. The resident was found on the floor, holding her stomach, complained of abdominal pain, not able to breath, and restless. Staff provided a nebulizer treatment (mist inhaled treatment for lung disease), lorazepam (medication for anxiety and agitation), and morphine (medication for severe pain). Staff contacted hospice and emergency medical services (EMS) for a lift assist off the floor. EMS transported the resident to the emergency room.

The resident's emergency room record indicated the resident arrived at the emergency room, was alert, and in acute distress. The resident was recently placed on hospice, DNR/DNI (do not resuscitate, do not intubate), and comfort cares only. The resident fell and hit her abdomen on a dresser and developed abdominal distension and significant pain. The resident's scan revealed a splenic laceration. The resident passed away at 11:11 a.m.

The resident's death record indicated the cause of death was due to complications of blunt force abdominal injury and fall.

The residents progress notes indicated three weeks prior to the fall the resident admitted to hospices services. Before admission to hospice, the resident received physical therapy. Nursing staff updated the resident's medical provider on lab results, chest x-ray results, and implemented various medication orders.

The resident's hospice records indicated the resident had a fall three months before admission to hospice services, hospitalized, and received treatment for pneumonia and heart failure. The resident returned to the facility with physical and occupational therapy services. Hospice admission records indicated the resident had declined since hospitalization and wished to no longer hospitalize. The resident's weakness had increased. The resident slept more during the daytime hours, had increased confusion, and dyspnea (shortness of breath). A chest x-ray showed lung disease and an enlarged heart. The resident used a walker with stand by assist, transferred independently but would benefit with a one staff assist. The resident was

independent with toileting and staff assisted to the bathroom. The resident dressed and groomed with staff stand by assist.

The residents service delivery record indicated the resident received services according to the service plan. The residents record did not indicate the facility assessed the resident after admission to hospice services. The service plan and service delivery record did not indicate changes before or after hospice admission. The resident received assistance with medication administration, compression stocking application, and showers.

During an interview, unlicensed personnel (ULP) 1 stated the staff provided assistance with the resident's medication administration and compression stocking application. The resident was alert, oriented, had a call pendent, and walked independently. The resident could get up independently from a seated position. ULP 1 stated the resident's room was open, free of obstructions, free of clutter, and the resident did not frequently fall.

During an interview, ULP 2 stated the day the resident fell, she went to the resident's room to assist. The resident had an unwitnessed fall and staff responded to the resident's call pendent use. ULP 2 stated staff did not know how or why the resident fell. The resident was in pain. Staff called the nurse, hospice, and EMS. EMS brought the resident to the emergency room. ULP 2 stated the resident was independent with toileting and dressing. ULP 2 stated staff provided assistance with medication administration and compression stocking application. ULP 2 stated the resident was alert, oriented, and knew how to use her call pendent.

During an interview, registered nurse (RN) 1 stated the facility did not conduct an assessment after the resident admitted to hospice services.

During an interview, RN 2 stated the resident admitted to hospice services. The resident was independent with walking, transfers, and used a walker. RN 2 stated the resident received assistance with medication administration. The resident was alert, oriented, and knew how to use her call pendent. RN 2 stated the resident did not frequently fall.

During an interview, the resident's family member stated the resident's health was declining prior to the fall. The resident received assistance with medication administration, housekeeping, and was independent with other cares. The family member stated she seen the resident prior to the fall and did not notice any changes or anything different with the resident. The resident did not have a recent prior fall. She stated the resident was alert, oriented, had a call pendent, and would request staff assistance when the resident felt she needed it.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff responded to the resident’s call pendent use, administered medication, contacted hospice, and EMS.

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
	29719	A. BUILDING: _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST ANTHONY	2540 KENZIE TERRACE SAINT ANTHONY, MN 55418

(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 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: #HL297193768C/#HL297192121M On March 8, 2023, 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 48 residents receiving services under the provider's Assisted Living license. The following two (2) day correction order is issued. Correction orders may be issued at a later date during the investigation. The following correction order is issued for #HL297193768C/HL297192121M, tag identification 0510. The following correction order with a period to correct that was not a two (2) day correction order are issued for #HL297193768C/#HL297192121M, tag identification, 1620.	0 000	Minnesota Department of Health is documenting 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 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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0 000	Continued From page 1 The two (2) day correction order for #HL297193768C/#HL297192121M, tag identification 0510 was corrected on March 15, 2023, at 1:20 p.m.	0 000		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19. The deficient practice had the potential to effect all residents, staff, and visitors. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 510	Tag identification 0510 was corrected on March 15, 2023, at 1:20 p.m.	

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0 510	Continued From page 2 of the residents). The findings include: Personal Protective Equipment The licensee failed to ensure staff wore personal protective equipment (PPE) per Center of Disease Control (CDC) and the Minnesota Department of Health (MDH) guidelines. The MDH guidance titled, COVID-19 PPE and Source Control (Masking), PPE, and Testing Grid, dated November 2, 2022, indicated when entering a room of a resident who tested positive for COVID-19 and was on transmission-based precautions staff wore full COVID-19 PPE: respirator, eye protection, isolation gown, and gloves. On March 8, 2023, at 8:15 a.m., the evaluator entered the facility, executive director (ED)-A stated the licensee was in the midst of a COVID-19 outbreak. The licensee's list of residents who tested positive for COVID-19 during the outbreak included 21 residents, eight residents were currently isolated on transmission-based precautions. R2 R2's diagnoses included multiple sclerosis. R2's record indicated R2 tested positive for COVID-19 on March 5, 2023. On March 8, 2023, at 8:45 a.m., unlicensed personnel (ULP)-H was observed exiting R2's room and shut the door after exiting. ULP-H wore	0 510		

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0 510	Continued From page 3 a facemask and no other PPE. R2 had PPE supply outside his room and signage posted on the door that indicated instructions to clean hands, wear a gown, N95 respirator, eye-protection, and gloves. On March 8, 2023, at 8:45 a.m., ULP-H stated R2 tested positive for COVID-19, was isolated, and on precautions. ULP-H stated she did not put on PPE before she entered R2's room to assist him. ULP-H stated she should have put on PPE before assisting R2. On March 8, 2023, at 9:20 a.m., registered nurse (RN)-B stated it was an expectation staff wore full PPE when entering a COVID-19 positive resident room when on transmission-based precautions. RN-B stated full PPE included a gown, N95 respirator, eye-protection, and gloves. The licensee's policy titled "Donning & Doffing PPE" undated indicated staff wore full barrier isolation PPE when caring for residents with a high consequence infectious disease. Instructions included putting on a gown, N95 respirator, face shield, and gloves. TIME PERIOD TO CORRECT: Two (2) Days ********** A two (2) correction order was identified due to the licensee's failure to ensure staff wore full personnel protective equipment (PPE) in COVID-19 positive resident rooms. The correction order began on March 14, 2023, at 9:00 a.m., and was corrected on March 15, 2023, at 1:20 p.m.	0 510		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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 record review, the licensee failed to ensure the registered nurse (RN) reassessed a resident after a change in condition for one of one resident (R1) reviewed. 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	01620		

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01620	Continued From page 5 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 indicated the resident was admitted May 5, 2018. R1's diagnoses included congestive heart failure, and cardiomegaly (enlarged heart). R1's service plan dated June 29, 2022, indicated R1 required assistance medication administration, showers, weight and vital sign monitoring, and ted stocking application. R1's assessment dated December 21, 2021, indicated R1 was independent with dressing, grooming, bathing, bed mobility, and transfers. R1 used a wheeled walker or cane. R1 assessment dated March 26, 2022, indicated the assessment was conducted after a hospital stay. R1 was independent with dressing, grooming, toileting, bed mobility, and transfers. R1 uses a wheeled walker or cane. R1's progress notes dated May 25, 2022, indicated R1 had a chest x-ray and impression was prominent cardiomegaly. R1's progress notes dated June 1, 2022, indicated the licensee received orders for hospice evaluation. R1's progress notes dated June 6, 2022, indicated R1 admitted to hospice with the terminal diagnoses of hypertensive heart disease. R1's hospice records dated June 6, 2022,	01620		

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01620	Continued From page 6 indicated R1 had declined since hospitalization and wished to no longer hospitalize. R1's weakness had increased. R1 slept more during the daytime hours, had increased confusion, and dyspnea (shortness of breath). R1 used a walker with stand by assist, transferred independently and would benefit with assist of one. R1 was independent with toileting and staff assisted to the bathroom. R1 dressed and groomed with stand by assist. R1's record did not include an assessment after R1's admission to hospice services. On March 8, 2023, at 1:17 p.m. registered nurse (RN)-B stated a nursing assessment was not conducted after R1 admitted to hospice services on June 6, 2022. RN-B stated R1 had a change of condition, and an assessment should have conducted. The licensee's policy titled "Assessments, Reviews, & Monitoring" dated July 1, 2021, indicated a reassessment would conduct based on changes in needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		