Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304557583M
Compliance #: HL304553041C

Date Concluded: March 7, 2025

Name, Address, and County of Licensee Investigated:
Hawley Senior Living
923 5th Street
Hawley, MN 56549
Clay County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 staff failed to address a change in the resident's condition after the resident fell and hit her head, resulting in a delay of care. The resident was observed to be not acting the same and vomited after the fall, but emergency medical services were not called until seven hours later. The resident was brought to the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although staff failed to follow facility policy and procedure when they did not notify the registered nurse (RN) with a change in condition after the resident fell, it is unable to be determined if the actions or inactions of the staff members contributed to the resident's condition. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with transfers and all activities of daily living. The resident's assessment indicated the resident required assistance of two staff members for transfers.

Facility documentation indicated at 6:07 p.m., the on-call RN was called after the resident fell and hit her head. Staff were educated to begin neuro checks (a neurological assessment that determines how a person's nervous system is working), the resident's daughter was called, and a fax was sent to the primary care provider.

Neuro checks were initiated immediately after the fall by ULP at the facility. The first three neuro checks done 15 minutes apart indicate the resident's pupil reaction was a 2, which was sluggish, an abnormal finding. The ULP failed to immediately notify the RN. 90 minutes after the fall, the resident's oxygen was 87% (normal is 95% to 100%, a level below 92% could indicate hypoxia). The ULP failed to notify the RN of the abnormal oxygen reading. The resident's blood pressure was 160/110 (normal is 120/80, a reading greater than 140/90 would be stage two high blood pressure). The ULP failed to notify the RN of the abnormal blood pressure. The ULP recorded additional abnormal vital sign readings four more times over the next four hours and failed to notify the RN. When the night shift ULP took over the resident's care, she recorded abnormal vital signs again and contacted the RN at 12:38 a.m. to report low oxygen levels, a high blood pressure, and that the resident's eyes were red and glossy and not responding to light. The on-call RN directed staff to call 911.

Ambulance records indicated 911 was called at 12:45 a.m. and the ambulance arrived at 1:11 a.m.

The police report indicated responding officers were told the resident had fallen out of her wheelchair around 6:00 p.m. and struck her head on the floor. The responding officer "observed a large abrasion" on the resident's left side of her forehead and that staff reported the resident was "not acting the same" as she usually did after the fall. Staff reported to police that the resident's eyes have been monitored since the fall and have shown to have "difficulty dilating properly." The resident was noted to have vomited at least once since falling. The responding officer "inquired to why medical was not contacted until almost seven hours later. She stated they just started their shift at 2300 hours and did not know why staff earlier did not contact EMS. She further stated those records were located in the office and it was currently locked, inaccessible."

Hospital records indicated the resident was diagnosed with a head contusion (an injury to the head) and after being evaluated in the emergency room, discharged back to the facility the next day.

During an interview the registered nurse (RN) stated she initially didn't have any concerns about the resident's transfer to the emergency room but confirmed after reviewing the neuro check sheet, staff should have called the nurse as soon as they noticed a change and confirmed there was a delay of care.

During an interview, the ULP working when the resident fell stated as soon as the resident fell and threw up, she immediately called the on-call RN and told her she felt the resident needed to be sent into the emergency room. The ULP stated the on-call RN told her they [the emergency room] "weren't going to do anything for rugburn" and told her to do vitals and start neuro checks. The ULP stated she couldn't find a neuro check sheet at the facility, so she found one off Google and printed it off. The ULP stated there was not a place to document oxygen, but she thought oxygen would be important to monitor so she added a line for it. The ULP stated she had not been trained on how to complete neuro checks previously. The ULP stated she was aware the resident had some out-of-range vital signs but did not call the on-call RN back because the nurse was crabby when she called earlier, and she felt she wouldn't take it seriously. The ULP stated she didn't know the ranges for what abnormal or normal vital signs would be but their blood pressure monitor would alert if it was high. The ULP stated she knew the resident's oxygen was low, but since it came back up, she continued to just record the vital signs. The ULP stated she wanted to send the resident in right after she threw up but didn't feel the on-call RN listened to her concerns and she didn't call her back because she felt like she would be a bother if she called her again.

During an interview, ULP working on the night shift stated she didn’t recall hearing anything in shift report about concerns with the resident's vital signs and was just told to do neuro checks. The ULP stated she noticed on the neuro sheet that the resident had previous abnormal vital signs but wasn't sure what the prior shift had done about it. Another ULP working the night shift stated she was asked by the other night shift ULP to verify the resident’s abnormal vital signs and noticed her blood pressure was elevated, her oxygen was low, and her pupils weren't responding normally. The ULP stated she knew the resident fell on the prior shift, so they decided to call the on-call nurse. The ULP stated when emergency responders arrived, they asked why this was the first time they were being called if the resident had been having abnormal vital signs for a few hours. ULP-D stated she wasn't sure what was done on the prior shift but they had noticed abnormal vital signs, so they called the nurse.

During an interview, the on-call RN stated she was notified of the resident's fall shortly after it happened, and she advised the ULP to initiate neuro checks. The on-call RN stated vitals initially reported to her were within normal limits. The on-call RN stated she was not updated of any concerns until the night shift staff called her to report their concerns and based on their report,

she felt the resident should be seen in the emergency room, so she walked the staff through to process of sending the resident in and calling 911.

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: Unable due to cognition
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:
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
	30455	A. BUILDING: _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWLEY SENIOR LIVING	923 5TH STREET HAWLEY, MN 56549

(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 January 9, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304557583M/#HL304553041C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State 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.	