Protecting, Maintaining and Improving the Health of All Minnesotans

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State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357959526M
Compliance #: HL357957331C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Havenwood of Burnsville
14401 Grand Avenue
Burnsville, Minnesota 55306
Dakota County

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

Evaluator's Name: Nicole Myslicki, 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 multiple times. The resident's health deteriorated, and the resident could no longer walk.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Evidence did not indicate the facility neglected the resident. Although the resident died as a result of a recent fall, the resident had been on hospice due to his health declining. The facility implemented interventions after falls, contacted the provider, and communicated with family.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice. The investigation included review of the resident record, death record, hospital records, hospice records, physical therapy notes, facility incident reports, personnel files, staff schedules, and related facility

policy and procedures. Also, the investigator observed the memory care unit, as well as residents and how staff engaged with and assisted them.

The resident resided in an assisted living memory care unit. The resident's diagnoses included weakness and frequent falls. The resident's service plan included assistance with safety checks every two hours, toileting, medication administration, and mobility. The resident's service plan also included the potential or actual risk for falls and injuries. Interventions in place included educating and encouraging the resident to use his call button, encouraging the use of assistive devices, ensuring the resident had adequate lighting at night and supportive shoes, keeping the resident's environment free of clutter and personal items nearby, and using a raised toilet seat. The resident's assessment indicated he occasionally had poor judgement, made unsafe decisions, and had a high potential for falls. This assessment also indicated the resident required hands on assistance and used a wheelchair or walker for mobility.

The resident's record indicated the resident fell numerous times while at the facility. Generally, these falls were unwitnessed or witnessed by his wife. The facility encouraged the family to transfer the resident into the memory care unit for closer observation and increased care.

An incident report indicated the resident fell, likely while attempting to use the bathroom. The resident denied pain but grimaced and said "ouch" when moved. At baseline, the resident did not need support to walk but required three staff to support him after the fall due to being unable to support his own body weight. The resident did not have a fever but had three loose stools that day and a history of clostridium difficile (an infection of the large intestine causing diarrhea), so the facility sent the resident to the emergency department with family approval.

The resident's hospital record indicated the resident had an elevated heart rate, fever, and reported a little bit of a cough, but he did not appear in acute distress overall or in respiratory distress while in the emergency department. The hospital diagnosed the resident with COVID. During his hospitalization, the resident developed a productive cough, low oxygen levels, and bacterial pneumonia. The resident returned to the facility after six days.

A progress note indicated the resident returned from the hospital and required assistance of one staff with walking, transfers, and cares. Another progress note indicated the facility obtained an order from the resident's provider for physical therapy (PT) to evaluate and treat for gait, balance, and strengthening.

PT notes indicated the resident participated in therapy sessions but needed cues, became fatigued, and sometimes struggled to stay alert through the sessions.

A progress note indicated the family chose to discontinue PT services and pursue hospice. The resident admitted onto hospice the next day.

Another incident report indicated the resident had been found on the ground after experiencing an unwitnessed fall. The resident reported he tried standing up from his wheelchair to change the channel on his television. The facility and hospice assessed the resident and agreed he should have an x-ray completed. The facility notified the resident's provider regarding the fall and asked for an order for the x-ray. The provider did not provide an order for an outside service to complete an x-ray but wanted the resident to go to the provider's office for an assessment. The facility, family, and hospice agreed to continue comfort measures instead of bringing the resident into the provider's office due to his pain level.

A progress note indicated the family declined to have the resident sent to the emergency department for an x-ray and continue comfort cares through hospice.

The medication administration record indicated he received narcotic pain medication and medication for muscle spasms and anxiety.

The service delivery record indicated he received his scheduled services, including toileting and safety checks.

A progress note indicated the resident died five days after this last fall.

The resident's death record indicated he died from complications of immobility due to a right leg fracture from a fall.

The resident's hospice records indicated the facility and hospice were in communication regarding the resident's condition, pain, and medications during end of life.

During an interview, the licensed assisted living director (LALD) stated the resident started falling after he initially moved into assisted living. A lot of the time, he either did not want to wait for assistance, or he did not use his call button. A couple of times he fell, his wife used her call button afterward to get help. The resident also had poor eating habits which made him thin and fragile. Staff at the facility were all concerned about his falls. They tried to help and work with him and encouraged the use of his call button. The facility held care conferences with family, encouraged them to move the resident to memory care, and get a different bed set up so the resident and staff could more easily maneuver around the bed.

During an interview, nurse-1 stated the some of the resident's falls seemed to be related to a lack of judgement and not drinking a lot of fluids. Additionally, the resident refused cares sometimes, although this improved after he moved to the memory care unit. The resident's COVID diagnosis seemed to come out of nowhere, since he had not been displaying symptoms. After this, the resident seemed like a different person and could no longer transfer on his own. He slept most of the day and needed assistance with everything. COVID took a toll on the resident, and hospice was ultimately the best thing for him.

During an interview, nurse-2 stated when the resident fell for the last time, staff tried to obtain an order for a portable x-ray company to complete an x-ray at the facility. The provider, however, declined to order this. Because the resident had been on hospice, the resident would have had to discharge off hospice if he went to the emergency department. They gave family the option to send him in or not, and the family chose to have hospice help manage his pain. There had been an issue with the resident's narcotic orders being transcribed into the

During an interview, a family member stated he felt like the resident did not get the care he should have received.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility contacted the provider, implemented interventions to attempt to help prevent future falls, and communicated with family and hospice.

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
	35795	A. BUILDING: _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF BURNSVILLE	14401 GRAND AVENUE BURNSVILLE, MN 55306

(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 May 1, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL357957331C/#HL357959526M. No correction orders are issued.	0 000		