Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201041880M
Compliance #: HL201049668C

Date Concluded: July 24, 2024

Name, Address, and County of Licensee Investigated:
Elder Homestead
11400 4th Street North
Minnetonka, MN 55343
Hennepin County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 facility staff failed to follow the care plan resulting in the resident falling and being hospitalized with a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility nursing staff failed to immediately implement provider orders and failed to assess the resident and update the medical provider when a change in condition occurred, resulting in a delay of care. The resident fell and staff failed to assess, monitor, and update the resident's medical provider, after an increase in pain and decline in mobility status were observed. The resident was later transferred to the hospital and diagnosed with a hip fracture that required surgical repair.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, death

records, hospital records, facility internal investigation documentation, facility incident reports, staff schedules, and related policies and procedures. At the time of the onsite visit, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit with a diagnosis of dementia. The resident's service plan included assistance with dressing, medication, and pain management. The resident was independent with a walker for ambulation. The resident's assessment indicated the resident had a history of falls, was confused with short-term and long-term memory loss, but able to communicate her needs.

Facility documentation indicated staff were in the resident's room when the resident attempted a self-transfer out of bed and fell. An incident report indicated the resident sustained an injury to the right side of her nose. The resident rated her pain as 5 out of 10 and scheduled Tylenol was administered. The incident report did not indicate if range of motion (ROM) was completed to the resident's upper or lower extremities following the fall.

The next morning, the resident reported pain of 10 out of 10 in the right hip and pain with ROM. The resident was unable to move her right leg independently and could not get out of bed due to the severity of the pain. The medical provider was updated and stated she would visit the resident later that day.

Medical provider documentation indicated the resident required assistance from two staff to transfer and the right hip was externally rotated (when the leg rotates outward away from the body, indicative of fracture). The medical provider ordered for hospice to evaluate and treat the resident, ordered an x-ray of the right hip and pelvis, and directed staff to update with changes as needed.

Hospice agency staff did not immediately evaluate the resident. The resident's medical record lacked evidence of ongoing assessment of the resident's condition, pain, or ROM, following the fall and the provider's visit after the fall. There was no documentation to indicate that the medical provider was updated about hospice not immediately evaluating the resident or the resident's ongoing hip pain and immobility. The medical record included no evidence of administration of additional pain medication or implementation of interventions to manage or alleviate pain while the resident remained in bed for two days following the fall.

The x-ray was not completed until two days later, after the provider questioned nursing staff on the results of the x-ray. The preliminary x-ray results were indicative of a possible hip fracture. The medical provider's notes indicated a facility nurse called the resident's family member about the x-ray results and the resident was sent to the emergency room for further evaluation.

The hospital record indicated the resident was provided intravenous (IV) pain medication in the ambulance and emergency medical technicians (EMT)s reported a right hip deformity. The resident was diagnosed with a right femur fracture and underwent surgery to repair the

fracture. The resident later discharged to a transitional care unit (TCU) to receive a higher level of care and did not return to the facility.

During an interview, facility nurse #1 stated she evaluated the resident after the fall and reported the pain to the medical provider. The medical provider did not order additional pain medication, and no additional contact was made to the provider to request additional pain medication or report an increase in pain. Facility nurse #1 stated she faxed the provider's orders for the x-ray, but the x-ray company never received the orders. The orders were not faxed again until three days later and the company completed the x-ray that same evening. Facility nurse #1 could not remember if the resident was monitored for pain following the fall or if pain medication was administered to the resident.

During investigative interviews, multiple unlicensed staff reported the resident was bedbound after the fall. The resident did not verbalize pain, but grimaced when cares were provided. Staff could not recall if medication was given for pain but reported the facial grimacing to facility nurses.

During an interview, facility nurse #2 stated she was on leave when the resident fell and did not return until after the resident was sent to the hospital. Facility staff provided care to the resident; however, the resident was unable to get up out of bed following the fall due to pain. The nurse indicated the resident's pain was treated with scheduled Tylenol and the resident did not display non-verbal signs of pain "all of the time" so nursing staff decided not to send her to the hospital. Facility nurse #2 stated the medical provider was under the impression that hospice staff would come out right away and manage the resident's pain but that did not occur. Facility nurse #2 was not aware if the medical provider was contacted regarding the resident's ongoing pain or if the provider was informed that hospice did not immediately evaluate the resident. Facility nurse #2 stated she did not assess the resident but stated that had she known the resident's hip was externally rotated, she would have sent the resident to the hospital sooner.

During an interview, the medical provider stated she expected facility staff to update her if the resident continued to have pain and request additional pain medication. After the medical provider's initial visit, the facility did not reach out to her to report the resident was in extensive pain or bedbound due to the pain. The medical provider stated they were under the impression that the resident was comfortable as there was no follow up provided by the facility regarding a change in condition.

During an interview, a family member stated the resident had a history of falls. The family member stated she was not notified of the fall until the x-ray came back with a possible hip fracture. The family member stated if she would have been told about the resident's pain, she would have requested for the resident to be sent to the hospital. The family member stated that they couldn't imagine being elderly, having a fracture, and not being sent to the hospital right away. The family member stated the resident never returned to her baseline condition

after the fall and subsequent surgery. The family member stated the facility and medical provider could have done more to provide adequate care and pain management following the fall.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

Action taken by facility:
The facility updated the medical provider and sent the resident to the emergency room after an x-ray revealed evidence of a hip fracture.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20104	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER HOMESTEAD	11400 4TH STREET NORTH MINNETONKA, MN 55343

(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 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: #HL201049668C/#HL201041880M On June 3, 2024, 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 33 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for ##HL201049668C/#HL201041880M , tag identification 2310 and 2360.	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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for one of four residents (R1) reviewed for falls, when provider orders were not immediately followed and the medical provider was not updated after reports of an increase in pain and immobility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of 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 diagnoses included unspecified dementia and chronic pain. R1's service plan dated January 8, 2021, indicated the resident received services includin toileting, medication management, and pain management. R1's facility incident report dated January 15, 2024, at 7:50 a.m. indicated that facility staff were in R1's room preparing her medication when R1 attempted to get out of bed and fell. The incident	02310		

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02310	Continued From page 2 report indicated R1 had an injury to the right side of her nose and indicated pain was 5/10 and scheduled Tylenol was administered. The incident report lacked evidence range of motion (ROM) was completed. R1's provider portal notes dated January 15, 2024, at 8:00 a.m. indicated R1 had a fall in her room. Licensed practical nurse (LPN)-B indicated unlicensed personnel (ULP)-D was in her room when R1 fell and hit her face on the dresser. ULP-D reported R1 had no injuries but R1 did state she hit her eye and was having trouble seeing out of it. R1 had a small laceration on the left side of her nose. R1's progress note dated January 15, 2024, at 8:30 a.m. indicated R1 had a fall, R1 was evaluated for injuries, MD, family, and appropriate staff notified. R1's progress note dated January 16, 2024, at 10:40 a.m. indicated director of nursing (DON)-A received a call from facility staff that R1 was having pain in her right hip and wasn't able to move it. LPN-B noted she checked on R1 and asked her about her hip pain. R1 stated she had 10/10 right hip pain. LPN-B noted she completed range of motion on her right leg and any movement up and down was causing a lot of pain. R1 did not have pain on palpation but when being rolled over on her right side R1 reported pain. R1 was not able to get out of bed due to the pain being severe. R1 was able to walk to the dining room the evening prior but now could not perform her normal night routine and R1 had to be changed in bed due to how much pain she was in. R1's portal notes dated January 16, 2024, at	02310		

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02310	Continued From page 3 10:49 a.m. indicated LPN-B updated physician assistant (PA)-G that DON-A received a call from facility staff that R1 was having pain in her right hip and wasn't able to move it. LPN-B noted she checked on R1 and asked her about her hip pain. R1 stated she had 10/10 right hip pain. LPN-B noted she completed range of motion on her right leg and any movement up and down was causing a lot of pain. R1 did not have pain on palpation but when being rolled over on her right side R1 reported pain. R1 was not able to get out of bed due to the pain being severe. R1 was able to walk to the dining room the evening prior but now could not perform her normal night routine and R1 had to be changed in bed due to how much pain she was in. LPN-B requested the PA-G's recommendations. R1's portal notes dated January 16, 2024, at 12:09 p.m. indicated PA-G stated she would see R1 that afternoon. R1's portal notes dated January 16, 2024, at 1:07 p.m. indicated R1 was seen today for hip pain. PA-G ordered hospice to evaluate and treat and an x-ray of the right hip and pelvis. R1's portal notes dated January 16, 2024, at 8:04 p.m. indicated PA-G was going to see R1 next week due to her hip pain and change in status. PA-G indicated to update her sooner as needed and to let PA-G know when the x-ray results are done. R1's portal notes dated January 17, 2024, at 9:03 a.m. indicated LPN-B acknowledged PA-G's note and indicated she would fax the results when the x-ray was completed. R1's portal notes dated January 17, 2024, at	02310		

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02310	Continued From page 4 12:35 p.m. indicated PA-G questioned why the x-ray had not been ordered to be completed. R1's portal notes dated January 17, 2024, 1:13 p.m. indicated LPN-B stated she sent the fax that morning but would fax again. R1's progress notes dated January 18, 2024, 4:24 p.m. indicated the x-ray company came and took x-rays. Family member (FM)-E was notified. R1's progress notes dated January 18, 2024, 5:30 p.m. indicated R1 was sent to the hospital with a possible hip fracture. FM-E was updated. R1's medication administration record for the month of January 2024 indicated no as needed (PRN) pain medications was administered throughout the month. R1's medical record lacked evidence of ongoing assessment of R1's condition, or ability to complete ROM, from the time of the 10:40 a.m. progress note until a progress note entered at 5:30 p.m. when R1 was sent to the hospital. R1's medical record lacked evidence PA-G was updated after the initial visit regarding ongoing hip pain and lacked evidence the licensee administered additional pain medication for R1's pain or provided any pain relief for January 16, 2024, January 17, 2024, and January 18, 2024, the days following R1's fall. R1's hospital record dated January 18, 2024, 6:29 p.m. indicated R1 was provided intravenous pain medication in the ambulance and emergency medical technicians (EMT)s reported right hip deformity. R1 was diagnosed with a right femur fracture, and she underwent a closed reduction, intramedullary nail fixation right intertrochanteric	02310		

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02310	Continued From page 5 femur fracture. After the surgery R1 was diagnosed with hypoactive delirium (a serious condition that's characterized by reduced motor activity, lethargy, and withdrawal). R1 was discharged to a transitional care unit after hospitalization. On June 3, 2024, at 10:50 a.m., LPN-B stated she evaluated R1 after the fall and reported the pain to PA-G. PA-G did not order pain medication, and LPN-B did not request any. LPN-B stated she faxed the orders to get the ordered x-ray, but the company never received the orders. The orders were faxed again on January 17, 2024, and the company completed the x-ray that evening. LPN-B could not remember if pain was being monitored after the fall or if pain medication was given to R1 beyond the scheduled Tylenol. On June 3, 2024, at 1:00 p.m., ULP-D stated when she worked with R1 in the days after the fall R1 reported pain when we would reposition her with pillows or when we would get her out of bed. R1 stated her pain was in her hip. ULP-D stated she gave her a PRN pain medication and reported R1's pain to the nurse. On June 4, 2024, at 10:50 a.m. DON-A stated she was out ill when R1 fell and did not return until she was sent to the hospital. The facility staff were able to provide cares for R1 however R1 was not able to get up out of bed in the days after her fall because of her pain. R1's pain was treated with scheduled Tylenol. Nonverbal signs of pain were not shown "all the time" so we decided not to send her in to the hospital. DON-A was not aware if PA-G was contacted regarding R1's ongoing pain. DON-A stated PA-G was under the impression hospice would come out right away and manage R1's pain but that was	02310		

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02310	Continued From page 6 not the case. DON-A stated she was not able to assess R1 but if she had known the hip was externally rotated, she would have sent R1 to the hospital sooner. On June 4, 2024, at 1:40 p.m. PA-G stated her expectation was if R1 continued to have pain, the facility nurses would request additional pain medication beyond her scheduled Tylenol. After PA-G's the facility nurses did not reach out to report R1 was in pain. PA-G stated facility nurses did not reach out with additional concerns, so she assumed R1 was comfortable. On June 4, 2024, at 9:30 a.m. FM-E stated R1 had a history of falls. R1 stated she was not notified of the fall the day it occurred. FM-E stated if she would have been told R1 was in pain she would have had R1 sent to the hospital. FM-E stated she couldn't imagine being elderly, having a fracture and not being sent in right away. FM-E stated a physician at the hospital told her hypoactive delirium could have been contributed to the trauma. The fracture and pain caused the trauma. FM-E stated R1 never returned to her prior condition after the fall and surgery. The licensee's policy Fall Management Program dated August 2018 indicated all staff are educated on the 5p's including personal items, personal needs, positioning, pain, and proper sleep. The policy indicated the licensee would implement appropriate interventions. The licensee's policy Initial and Ongoing Resident Evaluations and Assessments dated August 1, 2021, indicated a registered nurse will complete a change in condition assessment on a resident. The uniform assessment tool will be used and includes assessment of pain including, location,	02310		

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02310	Continued From page 7 frequency, intensity, durations and effectiveness of medication and non-medication alternatives. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		