Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL221397224M
Compliance #: HL221393708C

Date Concluded: January 24, 2024

Name, Address, and County of Licensee Investigated:
The Terraces Assisted Living
901 Feltl Court
Hopkins, MN 55343
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 the staff member failed to notify the physician about a broken hip, and the resident had to wait for two days before being sent to the hospital for further treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. A therapeutic error occurred when X-ray results arrived at the facility over the weekend and the nurse working faxed the results to the medical provider instead of contracting a medical provider, perhaps an on-call medical provider, by phone. Two days later when the resident was hospitalized, the decision was made to not treat the hip fracture surgically.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures,

incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include cognitive impairment. The resident's service plan included assistance of one person including dressing and toileting. The same assessment indicated she transferred and walked independently with a walker.

One Thursday afternoon the progress notes indicated the resident was found lying on the floor in her room stating she was trying to get to the bathroom and slid off her bed. She said she hit her head and compliance of left hip pain. Nurse #1 assessed the resident and updated the medical provider. The same note indicated nurse #1 she attempted to reach family but was not able to reach them, so she left a message requesting a call back.

On Friday morning, nurse #2 indicated the facility was waiting for the X-rays to be completed.

On Friday evening the portable X-ray service came to the facility and completed the X-ray on the resident.

On Saturday morning the X-ray was faxed to the facility and nurse #3 subsequently faxed the report to the medical provider when she came to work. The X-ray report indicated the resident had a left hip fracture.

On Monday, the progress notes indicated nurse #4 spoke with the medical provider about the X-ray results, who ordered the resident go to emergency room.

The hospital records indicated the resident's left hip fracture was confirmed by the emergency room and the resident was admitted to the hospital. However, the decision was made to not pursue surgical treatment and focus on comfort for the resident.

During an interview, a family member stated she was not informed of the resident's fall although she saw one missed call with no number and a voicemail with no sound. Four days later, she received a call from a nurse informing her the resident would be sent to the hospital because she had fallen. The family member stated they visited the resident a couple of days before the fall, and the resident's mobility was really bad; she could not pull herself up to use the bathroom and needed assistance from two persons. The family member stated the resident was not sent to the hospital until four days after the fall. Due to the resident's condition, the decision was made to not pursue further treatment and the resident entered hospice. The resident did not return to the facility.

During an interview, a management staff member stated the resident had a fall and the Xray technician came out the next day and the result was received a day after that. The nurse was on

duty that weekend faxed the result over to the medical provider but based on policy the nurse was supposed to call, not fax these results to the medical provider.

During an interview with nurse #3 she stated she worked that weekend and was the only nurse on the evening shift. She stated she received pain medications, and she recalled helping her use the toilet, which the resident was able to do. Nurse #3 stated she was unaware of the resident's fall from a few days earlier. She stated her supervisor informed her of the resident's fall at a later time when she returned to work. She stated she did not specifically recall receiving the X-ray results.

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.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The nurse who neglected to contact the provider upon receiving the X-ray results received a written warning, and additional education was provided.

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
	22139	A. BUILDING: _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES ASSISTED LIVING	901 FELTL COURT HOPKINS, 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 On December 13, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL221397224M/HL221393708C. No correction orders are issued.	0 000		