*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306253702M
**Compliance #:** HL306254086C

**Date Concluded:** August 8, 2024

**Name, Address, and County of Licensee Investigated:**
Northern Oaks Place
1005 Paul Parkway
Blaine, MN 55434
Anoka County

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

**Evaluator's Name:** Brandon Martfeld, RN BSN
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 had a change in condition, was sent to the hospital and was found with an injury of unknown origin.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. When staff observed a change in the resident's condition, staff assessed the resident and arranged for the resident to be evaluated at a hospital. The resident's diagnoses included a chronic (long term) previous hardware fracture with displacement (joint pushed out of usual place) of the resident's right elbow.

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 the resident records, death record, hospital records, facility

incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interacting with residents at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, hallucinations, and delusions. The resident's service plan included assistance with dressing, toileting, medication administration, and safety checks. The resident's assessment indicated the resident transferred independently and walked with occasional supervision from staff. The resident had severe cognitive impairment and had no falls.

The facility's progress notes indicated one afternoon the resident refused to come out of his room for lunch. Approximately 30 minutes later, the resident was checked on and was found asleep. The progress note did not identify any further concerns that evening. The next morning the progress notes indicated the resident needed assistances with eating breakfast. After breakfast the resident went back to sleep. At mid-day a facility nurse checked on the resident and observed the resident would not open his eyes upon wakening and did not have equal hand grip strength. The resident's provider was notified, and the resident was transported to the hospital.

The resident's daily schedule services indicated services were provided to the resident as care planned.

The resident had no prior falls reported for the 16 months that were reviewed.

The hospital records indicated the resident had an x-ray completed and was found to have a chronic fracture of previously placed hardware of the resident's right elbow with displacement of the joint.  The resident was not a candidate for surgical interventions.

The resident's death record indicated the resident passed away from throat cancer less than two months after being sent to the hospital.

During an interview, leadership stated the resident walked in the facility without any assistive devices. Leadership stated they were not aware of the resident having any falls at the facility. The resident often would put himself on the floor in a controlled manner looking for unknown objects or attempting to fix imaginary items on the floor.

During an interview, the resident's family member stated the resident worked as a tree trimmer and fell from a tree many years ago. The resident suffered a fractured ankle and had a metal plate in his ankle. The family member stated they were not aware of a metal plate in the resident's right elbow, but figured the metal plate in the elbow came when the resident fractured his ankle. The family member stated the resident was discharged from the hospital to a higher level of care facility.

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 resident was sent to the hospital when a change in condition was observed.

**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 |
|---|---|---|---|
| | 30625 | A. BUILDING: _____ B. WING _____ | C 07/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTHERN OAK PLACE | 1005 PAUL PARKWAY NE BLAINE, MN 55434 |

| (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 |
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| 0 000 | Initial Comments<br><br>On July 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306253702M/#HL306254086C. No correction orders are issued. | 0 000 | | |