Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306257106M
Compliance #: HL306253427C

Date Concluded: November 19, 2023

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

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 nurse failed to conduct an assessment for a change of condition, and upon the resident's return from the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident experienced three falls during her first month at the facility, and the staff follow the fall protocol to ensure her well-being. Although the facility could not provide a fall assessment document after each incident, they did have fall incident reports. The resident received proper care and returned to her baseline health condition.

The investigator conducted interviews with nursing 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 memory care unit and had a diagnosis of dementia. The resident's service plan included assistance of one with a walker and safety check every two hours. The resident's assessment indicated the resident was non-verbal.

The first fall indicated the resident was found on the floor of her room the day after admission with a noticeable bump on her forehead. The facility notified the medical provider, supervisor, and family. Immediate actions included performing vital signs and neuro checks while new interventions included safety checks and a referral for a physical therapy evaluation.

The next day the resident was transported to the emergency room the next day for further assessment due to home health nurse request. While in the emergency room the resident received a computed tomography (X-ray imaging combined with computer technology) which did not show injury. The emergency room returned the resident to the facility with no new orders.

Three days later the second fall incident report indicated the resident was found on the bathroom floor with a skin tear on her left elbow. The immediate action afterwards included vital signs and increases safety checks while awaiting the referral for a physical therapy evaluation.

A month later the third fall incident report indicated the resident was found on the bathroom floor with no apparent injuries. The facility obtained vital signs, notified the medical provider and the family.

Two days later the resident's progress notes indicated two days later a nurse contacted the resident's medical provider and requested an X-ray for the resident including her left shoulder, which showed left arm fracture. The resident saw an orthopedist a week later when the decision was made to not provide further treatment but rather monitor for pain or discomfort. Approximately a month later, the same documents indicated the resident showed sing of healing.

During an interview, a licensed practical nurse confirmed the resident fell three times since her admission to the facility. She explained that the resident's first fall occurred a day after admission, and the home health nurse observed a bump on her head the next day, prompting a request to send her to the hospital. The licensed practical nurse mentioned vital signs and a neuro check were conducted. The resident fell again a couple of days later, resulting in a skin tear. The nurse stated she did not record notifying the physician, but she recalled discussing the incident with the physician in person. Regarding the third fall, the nurse stated there were no apparent injuries at the time of the incident. However, a couple of days later, the resident did not use her left arm and appeared guarded. In response, the nurse requested an X-ray.

During an interview, a registered nurse stated she was not on site when the resident fell, however she was notified of the incident. While unable to recall the exact day of notification, she stated she reviewed the fall incident report a few days following the occurrence. According to policy, assessments were conducted after a resident return from the hospital or experiences any changes in condition. The nurse stated no changes were made to the resident's care services after the last fall, except for adjustments in the timing of her morning care. Additionally, she stated the resident has not experienced any further falls since then.

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 had dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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 10/17/2023

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
0 000	Initial Comments On October 17, 2023, the Minnesota Department of Health initiated an investigation of complaint HL306257106M/HL306253427C. No correction orders are issued.	0 000		