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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306688003M
**Compliance #:** HL306684121C

**Date Concluded:** January 30, 2025

**Name, Address, and County of Licensee Investigated:**
Tamarack Court of Bemidji
1511 Delton Avenue NW
Bemidji, MN 56601
Beltrami County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Barbara Axness, 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 alleged perpetrator (AP), an unlicensed personnel (ULP) at the facility, neglected the resident when she failed to transfer the resident according to their service plan. The resident fell and was transferred to the emergency room. The resident was diagnosed with a hip fracture.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had a fall while being transferred without a gait belt, the error was an isolated incident. The resident sustained a hip fracture and was hospitalized and returned to their baseline health condition.

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

hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included history of stroke and type two diabetes. The resident's service plan included assistance with activities of daily living, including transfer assistance. The resident's assessment indicated the resident needed an assist of one with a gait belt for all transfers.

The resident's record indicated the resident fell while walking with the AP. The resident complained of hip pain and was not able to bear weight on her right leg, so she was sent to the emergency room.

Hospital records indicated the resident was admitted with a hip fracture that required surgical repair. The resident later discharged to a skilled nursing facility with a plan to return to the assisted living after completing therapy.

The facility's internal investigation indicated the AP notified the RN after the fall to report that she had not been using a gait belt. The AP was suspended until she could be retrained on ambulation assistance and using a gait belt. All employees were trained on the importance of following care plans and reviewed policies related to ambulation assistance.

The AP's employee record indicated she had been appropriately trained on the resident's plan of care, ambulation policies, and use of a gait belt.

During an interview, a facility nurse stated the AP immediately reported she failed to follow the resident's plan of care, and they took action to ensure the employee was retrained and understood the importance of following the resident's plan of care.

During an interview, the AP stated she knew the resident should use a gait belt but had seen her walk independently before so thought it would be ok to not use one.

In conclusion, the Minnesota Department of Health 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, declined.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility reported the incident to MAARC. The facility conducted an internal investigation and retrained the employee involved in the incident.

**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 |
|---|---|---|---|
| | 30668 | A. BUILDING: _____ B. WING _____ | C 01/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TAMARACK COURT OF BEMIDJI | 1511 DELTON AVENUE NW BEMIDJI, MN 56601 |

| (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<br><br>On January 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306688003M/#HL306684121C. No correction orders are issued. | 0 000 | | |