

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339596605M
Compliance #: HL339599905C

Date Concluded: February 5, 2025

Name, Address, and County of Licensee

Investigated:

Havenwood of Richfield
245 West 76th Street
Richfield, MN 55423
Hennepin County

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

Evaluator's Name: James P. Larson, 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 facility and the alleged perpetrator neglected the resident when they failed to provide fall precautions after the resident previously had unwitnessed falls in his apartment. The resident then fell again and sustained injuries to his back and ribs that required hospitalization.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility and the alleged perpetrator (AP) followed the care plan, performed safety checks, and implemented fall precautions as directed. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident record, the facility internal incident reports, personnel files, employee training files, and facility policy and procedures. The investigator also toured the facility and observed staff members interacting with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia and type 2 diabetes mellitus. The resident's service plan included assistance with all activities of daily living, routine safety checks, and medication administration. The resident's assessment indicated the resident had a history of unwitnessed falls with injury, as well as impaired cognition with poor decision making and required supervision. The resident required hands-on assistance from one staff member for ambulation with a two-wheeled walker.

Records reviewed indicated that one evening while the alleged perpetrator (AP) was in the resident's apartment assisting with routine evening cares, they turned away from the resident to continue preparations, when the resident reached down to adjust his pants and began to lose his balance. The resident attempted to reach for his walker but missed and fell backwards landing on the heating register, injuring his back and ribs. The resident was assessed and transported to a local hospital for treatment of fractured ribs and spinal injuries.

During investigative interviews, multiple staff members stated they were aware of the resident's fall history and were informed of all additional fall precautions prior to initiating care of the resident.

During an interview with the AP she stated that on the evening of the incident she recalled being in the resident's room and as she was gathering supplies and turning down his bed, she witnessed the resident standing with his walker in the living room, bending down to adjust his pants. As he lost his balance, he attempted to reach out for his walker but fell backwards onto the windowsill.

During an interview, the resident stated that he has fallen on occasion but does not recall details about this incident. During the interview, he remembered sustaining an injury to his ribs but was not able to recall details of the fall. He also stated that the facility completes safety checks on him often throughout the day.

During an interview, the resident's emergency contact stated that they were contacted and informed of the incident and that they had no concern with care provided at the 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: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The nursing staff identified fall vulnerabilities in the nursing assessments and addressed precautions in the care plan to identify potential or actual risk for falls and injury. Additional training and review of proper transfer and ambulation procedures was completed with facility care team staff.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33959	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF RICHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 245 WEST 76TH STREET RICHFIELD, MN 55423
---	--

(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	<p>Initial Comments</p> <p>On January 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL339599905C/#HL339596605M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____