Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL348751560M
Compliance #: HL348755987C

Date Concluded: July 7, 2026

Name, Address, and County of Licensee Investigated:
Talamore Assisted Living
215 37th Ave. N
St. Cloud MN 56303
Stearns County

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

Evaluator's Name: Lori Pokela R.N.
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):
Neglect occurred after the resident had multiple falls with injury and the facility did not initiate post-fall interventions nor follow-up on a post-fall x-ray causing a delay in treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had a fall and had complaints of arm pain, the facility assessed, monitored, and implemented new interventions following the fall. Family was notified of the fall but did not want the resident sent to urgent care. The facility requested an x-ray from the provider for the resident's arm but did not receive the order prior to the resident being brought to urgent care by the family member. The resident was treated with Tylenol three times a day and application of ice.

The investigator conducted interviews with facility staff members, administrative nursing staff, and unlicensed staff. The investigator contacted resident's provider personnel. The investigation

included review of the resident record(s), hospital records, pharmacy records, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed the facility's physical plant, medication administrations, treatment administration, cares being provided and staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's Disease. The resident's service plan included assistance with grooming, putting on compression stockings, medication management, safety checks, housekeeping, laundry and coordinated care with a home care agency. The resident's assessment indicated the resident was oriented to person and place at the time of the incident with an occasional need for reassurance and redirection from staff. The resident's assessment indicated had a history of refusing services and transferred and ambulated with a wheeled walker independently.

A facility incident report indicated the resident self-reported he fell when getting off of the couch. Facility staff found the resident sitting on his apartment floor and assessed the resident to have no injuries, took the resident's vitals signs, assisted the resident back into his chair comfortably and notified the nurse, family and the resident's provider of the incident. A post-fall evaluation was completed the same date after the resident's fall and indicated the resident had a history of falls, the resident reported rolling out of bed, as the resident utilized his chair for sleeping and the resident later complained of pain in his right elbow and denied hitting his head. The post-fall interventions included a recommendation to increase services of staff assistance, educate the resident use his call pendent for all transfers, staff to continue post-fall monitoring, encourage fluids and report any change in condition.

Medical records indicated later that day a facility nurse called the resident's family member to report the resident had complained of pain in his left wrist and palm. A facility nurse asked if the resident should be sent in to be x-rayed however the family member requested the facility not call 911 and that the resident could wait until the following day if the resident needed to be seen by a provider. The resident's family agreed to the resident having an x-ray completed at the facility and the facility nurse called the resident's provider to obtain an order for the resident to have an x-ray of his left hand and wrist. The request was made to the provider however the facility never received a signed order to get an x-ray completed.

Medical records dated three days after the resident's fall indicated the resident was transported to urgent care and an x-ray was completed at that time. The resident's x-ray indicated the resident did not have any fractures of his left shoulder or humorous, [long bone in the upper arm], but revealed a one millimeter fragment in the resident's left elbow that may have been a fracture. Over-the-counter pain medication was prescribed as needed and to ice the elbow every twenty to thirty minutes three to four times per day.

During an interview, an administrative nurse stated the resident's services for staff assistance were discontinued by the resident's family a few weeks prior the resident's fall. The administrative nurse stated the facility requested an x-ray of the resident's left hand and were

informed that the x-ray would need to be covered by the resident's insurance and an order for the x-ray would be sent but the x-ray order never arrived. The resident did not have ongoing pain or a fracture of the left hand. The administrative nurse stated she recalled post-fall interventions to include encouragement of the resident to use the call pendent, education to the resident's spouse to not assist the resident and requests to the resident's family to increase services for staff assistance, including safety checks, but the resident's family declined.

During an interview, the resident's family member stated they were informed the resident could receive an x-ray for the left hand at the facility, but the facility did not receive an order for the x-ray to be completed. The family member brought the resident to urgent care and the resident reported he did not have a lot of pain. X-rays indicated a bone chip in the elbow. The family member stated that since the fall the resident had a couple more falls that required hospitalization. The resident's family member stated the resident had been observed to have increased confusion and was subsequently placed in a skill nursing facility where rehabilitation was completed and the resident awaited a bed on the facility's memory care to become open.

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, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Incident reports were completed by the facility.
Falls were reported to the resident's provider and family.
Post-fall interventions were updated following each fall.

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
	34875	A. BUILDING: _____ B. WING _____	C 06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37TH AVENUE NORTH SAINT CLOUD, MN 56303

(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 May 13, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL348755987C/#HL348751560M. No correction orders are issued.	0 000		