DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352309222M
Compliance #: HL352307767C

Date Concluded: April 16, 2025

Name, Address, and County of Licensee Investigated:
Urbana Place Senior Living
5601 94th Avenue N.
Brooklyn Park, MN 55443
Hennepin County

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

Evaluator's Name: Michele 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):
Two facility staff members/alleged perpetrators (AP) #1 and AP #2, neglected the resident when they failed to ensure the resident's safety while undressing the resident. AP#1 and AP#2 roughly removed the resident's clothing causing the resident to fall on the bathroom floor and sustain deep bruising and rib cage damage. In addition, AP#1 and AP#2 lacked knowledge on how to use a full mechanical sling lift (Hoyer) to assist the resident off the floor after he fell. The resident remained on the floor for a while until the fire department arrived and assisted the resident off the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Cares were provided in accordance with the resident's service plan. During the facility's internal investigation both AP#1 and AP#2's stories remained consistent. AP#1 and AP#2 followed facility procedure by not immediately getting the resident off the floor until he was assessed by

a facility nurse. Although the resident fell, his injuries did not require an evaluation at a hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, facility incident reports, AP#1 and AP#2 employee files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares during the onsite observations.

The resident resided in an assisted living facility. The resident's diagnoses included progressive supranuclear palsy (PSP) (rare, progressive brain condition that affects movement, balance, vision, speech, and swallowing). The resident's service plan included full assistance with transfers, toileting, and bathing. The resident required the physical assistance of one staff person with dressing tasks. The resident's assessment indicated the resident was alert and oriented and able to make his needs known. The resident used a specialized motorized wheelchair for mobility and transferred using a mechanical lift (EZ stand) with assistance of two staff. The resident received hospice care due to his terminal PSP diagnosis.

The resident's hospice record dated on the 7th and 8th of a month indicated the resident occasionally used supplemental oxygen during the day through a tube inserted into his nose (nasal cannula). The resident had limited movement in his limbs and no movement in his left arm. The resident's family member reported the resident was overall weaker with increased shortness of breath.

The resident's facility progress note dated on the 12th of the same month indicated the resident fell from the toilet seat while being assisted by staff. The resident's range of motion was within normal limits and vital signs were obtained. Other than a scratch on the resident's back no serious injuries were noted. The fire department arrived and transferred the resident to his specialized wheelchair.

The resident's hospice record indicated an hour after the fall, a hospice nurse arrived to assess the resident. The resident's family member stated at the time of the incident she was in the lower level of the facility while AP#1 and AP#2 assisted the resident on the toilet. The family member expressed frustration the resident fell while under AP#1 and AP#2's care. The hospice nurse observed a small abrasion and redness on the resident's shoulder but noted no signs of bruising.

The facility's internal investigation report indicated the resident was startled when one AP grabbed his left arm to put his shirt on which caused the resident to fall due to the resident's right hand was not holding the grab bar on the wall. In separate interviews AP#1 and AP#2 stated the resident's fall happened so fast, stating while one got his cleaning wipes ready the other went to put on his brief. The report indicated AP#1 and AP#2 followed the resident's service plan using two staff for transferring and one staff to change and dress the resident. The

facility called the fire department to assist the resident off the floor. The resident was transferred to his motorized wheelchair and made comfortable. AP#1 and AP#2 were reeducated on stand-by assist and to ensure the resident's right hand held onto the grab bar for stability. The facility updated the resident's service plan to include two staff members to assist the resident with all services to ensure the resident remained safe.

During an interview, leadership stated the resident's family member's account of what happened changed multiple times. Leadership stated she interviewed AP#1 and AP#2 separately stating both of their stories matched. During leadership's interview with the resident the family member insisted AP#1 and AP#2 grabbed and pulled the resident's shirt causing the resident to fall off the toilet, stating the resident only stated his right hand was not holding the right grab bar at the time he fell.

During an interview, AP#1 stated she and AP#2 were in the bathroom at the time the resident fell off the toilet, stating she was near the sink getting the resident's lotion and wipes together as AP#2 stood near the resident. AP#1 stated the resident was not being undressed or transferred when he fell, stating the resident fell onto the floor on his left side because there was no grab bar he could hold onto. AP#1 stated they called 911 for lift assist after they were unable to reach the facility nurse. AP#1 stated the resident's care plan was updated after his fall to require two staff on either side of the resident during toileting and the EZ stand in front of the toilet.

During an interview, AP#2 stated the resident's fall happened "In a split second," stating the resident slid off the toilet seat and onto the floor. AP#2 stated the resident's family member became angry at her when she called 911 stating the family member wanted hospice called instead. AP#2 stated facility procedure does requires the resident needs to be assessed by a nurse before they can lift him off the floor.

During an interview, the resident's family member stated the fire department recommended the resident be evaluated at the hospital, but stated the resident would refuse to go and she agreed with the resident's wishes.

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 facility conducted an internal investigation and updated the resident's service plan to include more staff assistance when toileting.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: ______ B. WING ______	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL352307342C/#HL352309044M #HL352307721C/#HL352309202M #HL352307767C/#HL352309222M On March 13, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 87 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL352307721C/#HL352309202M, tag identification 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a facility licensed practical nurse (LPN)-A, reported a pressure sore to one of one resident (R1)'s medical provider to initiate orders for home health management of R1's wound. LPN-A was instructed twice by licensed assisted living director (LALD)-C and registered nurse (RN)-B to evaluate and update R1's medical provider. LPN-A evaluated R1's pressure sore but failed to update R1's medical provider which led to a delay in initiating R1's wound care for several weeks. R1 developed an unstageable pressure sore requiring weeks of weekly wound care. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 was admitted to the licensee's facility on August 6, 2021. R1's diagnoses included severe protein-calorie malnutrition. R1's service check off list dated December 2024 indicated R1 received	02310		

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02310	Continued From page 2	02310		

assistance with personal cares, toileting, safety checks, and escorts. R1 used a wheelchair for mobility and a sit to stand lift for transfers.

R1's assessment dated December 19, 2024, indicated R1 had limited range of motion, impaired mobility, and weakness. R1 had no skin issues at the time she was assessed.

R1's progress note dated December 30, 2024, at 2:57 p.m., indicated LPN-A was informed R1 had an open wound on a leg. R1 denied having a wound and refused to have LPN-A assess her legs. R1's progress note lacked documentation LPN-A made additional attempts to assess R1's legs or communicated with facility leadership R1 refused to be assessed.

R1's record indicated no additional information was documented about R1's wound until two weeks later.

R1's progress note dated January 16, 22025 at 6:03 p.m., documented by LPN-A, indicated LPN-A attempted to reassess R1's legs as previously requested by LALD-C on December 30, 2024, but R1 refused stating she had no skin issues on her legs. No further reattempts were documented by LPN-A, or documentation LPN-A asked another floor nurse to assess R1, or update RN-B, LALD-C, and R1's medical provider.

R1's progress note dated January 17, 2025, at 10:13 a.m., documented by registered nurse (RN)-B, indicated a wound was noted to R1's left outer ankle. LPN-A's measurements of R1's wound indicated the wound was 2 centimeters (cm) x 1.5 cm x 0.3 cm. No further description of R1's wound was documented. RN-B indicated

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02310	Continued From page 3 LPN-A would follow-up with R1's medical provider to notify them of R1's wound and request recommendations and request for referral to home health agency for wound assessment and management. R1's record lacked documentation LPN-A contacted and updated R1's medical provider about R1's wound and to initiate wound care for R1's pressure sore. R1's progress note dated February 7, 2025, at 9:19 a.m., indicated RN-B contacted R1's medical provider to provide an update on R1's wound and to request a home health wound evaluation. RN-B indicated R1's medical provider was never notified about R1's wound until RN-B called and updated the provider. R1's progress note dated February 7, 2025, at 10:54 a.m., documented by RN-B, indicated upon review of R1's record, there were no progress notes documented by LPN-A indicating she followed up with R1's medical provider or notes a current treatment plan was implemented for R1's pressure sore. New measurements obtained of R1's wound indicated the length, width, and depth of the wound increased, measuring 2 cm x 2 cm x 0.5 cm. RN-B indicated R1's pressure sore appeared to be a full-thickness, stage 3 wound with adherent sloughing (presence of necrotic, dead tissue). R1's progress note dated February 13, 2025, at 1:16 p.m., indicated home health began treatment for R1's pressure sore on February 13, 2205, at 2:30 p.m. During an interview on March 20, 2025, at 8:11 a.m., LPN-A stated on December 30, 2024,	02310		

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02310	Continued From page 4 LALD-C requested she evaluate a wound found on R1's leg by unlicensed personnel (ULP). LPN-A stated an ULP said R1 had a wound on her leg but did not state the location of R1's wound. LPN-A stated R1 became angry when LPN-A asked R1 if she could look at R1's leg wound, stating R1 insisted she did not have a wound. LPN-A stated she documented R1's refusal and told LALD-C R1 did not have a wound. LPN-A admitted she never made further attempts to assess R1's wound after R1 first refused. LPN-A stated on January 16, 2025, RN-B asked her to assess and obtain measurements of R1's wound. LPN-A stated she took measurements of R1's wound and handed the measurements to RN-B, stating she assumed RN-B would update R1's medical provider since RN-B asked her for the measurements of R1's ankle wound, even though she acknowledged it was one of her nursing duties. LPN-A stated she resigned because of R1's wound incident in addition to an issue regarding a misplaced order, stating she felt badly treated by facility leadership. During an interview on March 31, 2025, at 11:00 a.m., RN-B stated she began working at the facility on January 6, 2025, one week after R1's pressure sore was first discovered. RN-B stated floor nurses were expected to monitor and update nursing leadership whenever a resident experienced a change in condition, stating she often delegated tasks to floor nurses. RN-B stated on January 16, 2025, she received a "Wisdom to Act" notice from an ULP indicating a wound concern on R1's ankle requiring a nurse follow-up. RN-B stated she immediately asked LPN-E to obtain measurements of R1's ankle wound then follow-up with R1's medical provider for an order for home health referral. RN-B stated on February 7, 2025 she received another	02310		

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02310	Continued From page 5	02310		

"Wisdom to Act" notice from an ULP inquiring if RN-B was aware of R1's ankle wound or if it was addressed. RN-B stated she immediately contacted R1's medical provider, measured R1's ankle wound, took photos, and updated regional nursing leadership. RN-B stated she took accountability for not following up with LPN-A but stated she fully expected LPN-A to complete the nursing task because LPN-A told her she would do so.

During an interview on April 1, 2025, at 3:00 p.m., LALD-C stated on December 30, 2024, she requested LPN-A assess a wound on R1's leg reported to her by an ULP and follow facility protocols for wound orders. LALD-C stated on February 7, 2025, she found out LPN-A never updated R1's medical provider or obtain orders for wound care, so she immediately conducted an internal investigation. LALD-C stated LPN-A admitted she did not make any further attempts to try and assess R1's wound before she documented R1 refused, stating LPN-A seemed to not understand she needed to make two additional attempts to assess R1's wound. LALD-C stated nursing leadership retrained LPN-A on wound care but stated shortly after RN-B found unprocessed orders stacked in the nurse's station LPN-A and two other LPN's overlooked. LALD-C stated LPN-A worked multiple day and evening shifts during the time the orders came through. LALD-C stated LPN-A refused to listen or take any responsibility for the orders not being completed. LALD-C stated the two other LPN's were suspended then retrained on processing orders stating the other LPN's took responsibility and seemed remorseful. LALD-C stated LPN-A resigned before she could be terminated.

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02310	Continued From page 6 The licensee policy titled Wound Care and Pressure Injury, updated August 2023, indicated the nurse was to notify the resident's physician as soon as possible but not to exceed 24 hours whenever a resident was assessed with alterations in skin integrity. No additional information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		