Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378508485M
Compliance #: HL378505750C

Date Concluded: December 27, 2023

Name, Address, and County of Licensee Investigated:
Norbella Senior Living Savage
14275 Joppa Ave South
Savage, MN 55378
Scott County

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

Evaluator's Name: Christine Bluhm, 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:
The facility neglected a resident when staff failed to start life saving measures such as a Heimlich maneuver (choking first aid) or cardiopulmonary resuscitation (CPR) for the resident who was choking and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility tended to the resident during an episode when he coughed on food while eating and became unresponsive. Staff stayed with the resident and called 911 to request emergency services.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of the resident's facility record as well as other resident records that resided in the memory care. Facility incidents, policies, and

protocols regarding resident change in status and emergency aid were reviewed. The investigator observed staff supervision of residents during dining services.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia and high blood pressure. The resident's service plan included assistance with all activities of living, medication management, housekeeping, and meal preparation. The most recent nursing assessment indicated the resident had been hospitalized and returned back to the facility with an order for a mechanical soft diet for difficulty chewing food. The resident required staff assistance during meals.

One morning the resident began choking during breakfast and a staff member began patting his back. The staff member witnessed the resident's face turn red and head slouched down and 911 was called. Staff wheeled the resident in his wheelchair to the nursing station to be with the resident while on the phone with 911. Emergency personnel arrived and started living saving measures until a do not resuscitate order was located. The facility staff members did not attempt a Heimlich maneuver or initiate CPR for the resident.

The 911 audio indicated the staff member told dispatch the resident seemed to be choking, had coughed up some food and was in and out of consciousness and needed emergency assistance.

The facility Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) indicated the facility does not require unlicensed staff to be CPR trained stating staff would call 911 and follow operator instructions. The same document indicated a registered nurse was onsite "full time" but did indicate unlicensed staff were in the building at all times.

The facility policy titled "Resident Emergencies/911 Calls," indicated staff were to call the nurse for any emergency or, if no nurse was immediately available onsite, to call 911 promptly. The same document indicated if any doubt about the seriousness of the resident's condition existed to defer to the judgement of the first responder's evaluation.

During an interview, the staff member stated she knew it was an emergency situation, which warranted a call to 911. She stated the nurse was not in the building so the protocol is to call 911.

During interview, the director of nursing confirmed staff member(s) acted appropriately without delay in care during the incident.

During interview, a family member stated the police department notified her that her father had passed away. She stated there was concern that staff had done nothing, like the Heimlich maneuver, for him.

The resident's death certificate lists the immediate cause of death as choking (on food) and manner of death as an accident.

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, he was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:
No 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
	37850	A. BUILDING: _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA SENIOR LIVING SAVAGE	14275 JOPPA AVENUE SAVAGE, MN 55378

(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 December 6, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL378505750C/#HL378508485M. No correction orders are issued.	0 000		