Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392688302M
Compliance #: HL392684840C

Date Concluded: April 2, 2025

Name, Address, and County of Licensee Investigated:
NorBella Centerville
2025 Michaud Way
Centerville, MN 55038
Anoka County

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

Evaluator's Name: Michele Larson, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 neglected a resident when they failed to address a change in the resident's condition after the resident complained of severe pain for days. The resident was later hospitalized and diagnosed with a hip fracture. In addition, the facility failed to perform daily wound care to the resident's left big toe as ordered by the resident's medical provider.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had a history of muscle spasms and periodically

took tizanidine (medication to relieve muscle spasms) for her muscle spasms. Days before the resident was hospitalized she complained of a new different pain in her left hip and arm, but facility nurses failed to assess the resident's new pain or update the resident's medical provider. Instead, the facility continued to administer tizanidine without monitoring the effectiveness of the medication. The resident's pain was unrelieved and continued to worsen over several days until the resident's family arrived at the facility and called 911. The resident was transported to the hospital and diagnosed with a hip fracture.

In addition, the resident was diabetic and was completely dependent on staff for cares including daily skin checks and monitoring a wound on her left big toe. Staff were to immediately report skin concerns to nursing staff, yet facility staff failed to notify nursing when the resident's left big toe wound reopened at an unknown date. The resident developed a red, swollen, weeping, wound on her left big toe.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's family members were interviewed. The investigation included review of the resident's facility record, death record, physician's orders, photos of the resident's wound on her left big toe, hospital record, hospice record, in-house provider record, facility internal investigation report, and facility incident reports. In addition, personnel files, staff schedules, and related facility policy and procedures were reviewed. The investigator observed staff and resident cares during the onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral infarction (stroke), left-sided hemiparesis (paralysis), Type 2 diabetes mellitus, and left neck of femur fracture (hip fracture). The resident's assessment indicated the resident was alert and oriented and able to make her needs known. The resident used an electric wheelchair for mobility and required a full mechanical sling lift (Hoyer) for all transfers with the assistance of two staff.

The resident's service plan indicated the resident was completely dependent on staff for her cares. The resident received daily skin checks and twice weekly bathing with the assistance of two unlicensed personnel. Unlicensed personnel were to immediately report skin concerns to nursing staff.

The resident's medication administration record indicated the resident was prescribed as needed (prn) medication for muscle spasms (tizanidine), 2 milligrams (mg), one tablet by mouth up to two times per day.

The resident's progress note indicated early one morning at 5:18 a.m. unlicensed personnel called the after hours on-call registered nurse (RN) requesting the resident's prn tizanidine after the resident reported a different, new pain in her left arm and hip. The on-Call registered nurse gave unlicensed personnel a verbal okay to administer 2 mg of tizanidine. Unlicensed personnel were to call back if the tizanidine was not effective in reducing the resident's pain.

Five nights later at 1:49 a.m., unlicensed personnel called the afterhours nurse after the resident rated her pain 10/10. (The worst pain experienced). The on-call nurse advised unlicensed personnel to administer the resident's tizanidine and requested unlicensed personnel obtain a pain score after administering the medication to monitor its effectiveness, but the resident's record indicated a pain score was never obtained or reported to the on-call nurse. In addition, the on-call nurse failed to follow-up on the resident's reported 10/10 pain or updated the resident's medical provider.

Two days later at 3:27 a.m., the resident complained of pain and spasms in her left arm and leg. The on-call nurse advised unlicensed personnel to administer 2 mg of tizanidine requesting unlicensed personnel to call back if the medication was not effective in reducing the resident's pain. The resident's record lacked documentation the resident's medical provider was updated.

Hours later, communication notes from a facility nurse to the resident's medical provider indicated the nurse reported the resident was in "a lot of pain" even after days of administering tizanidine. The nurse indicated staff were unable to perform the resident's cares due to the severity of the resident's pain level, indicating the resident requested her tizanidine almost every night. The nurse asked the physician if the medical provider could prescribe something for pain management. The resident's medical provider responded, requesting the facility confirm the resident's current prn pain medication however, the facility failed to reply to the medical provider's request.

The following day, unlicensed personnel called the on-call nurse, concerned the resident had been in "a lot of pain" for the past several days. Unlicensed personnel stated the onsite nurse was aware of the resident's pain and stated the resident's family members observed the resident's left foot was black and blue with an open wound on her left big toe, stating the "sore is pretty big." The on-call nurse documented she could hear the resident yelling and screaming in pain. The resident's family members called 911.

During several days the resident reported increased pain, facility nurses failed to assess the resident to determine the source of the resident's increased pain, implement interventions, monitor the effectiveness of the resident's prn muscle spasm medication, or update the resident's medical provider.

The resident's service delivery record indicated the resident never received any wound cleaning or wound monitoring for several weeks prior to her hospitalization.

The resident's hospital record indicated the resident's left leg was notably red and swollen when she arrived at the hospital. The resident was diagnosed with a closed left hip fracture. Family members questioned why the facility allowed the resident's increased pain to go unchecked for days. The resident's open wound on her left big toe was red, swollen, and measured 3 centimeters (cm) x 2 cm with no measurable depth. A thin layer of dead tissue

(slough) was on the wound with moderate clear drainage and tender to touch. Daily wound care was initiated, and the resident's big toe was monitored for signs of infection. A hospital doctor documented, "I have concerns that there was neglect at the facility given the severity of pain, edema (swelling) in her leg, and report that this has been going on for days without evaluation." Hospital doctors suspected the resident's left hip fracture was 10 days old, indicating because of the length of time that passed hip surgery would not be an option for the resident.

The resident was hospitalized for seven days then discharged back to the facility and admitted to hospice. The resident never returned to her baseline status and died one month later.

The facility's internal investigation indicated the resident had a history of complaining about muscle spasms but complained about new pain in her left hip and arm days before she was hospitalized. When interviewed, unlicensed staff stated the resident's prn muscle spasm medication seemed ineffective because the resident continued to yell out in pain, stating the resident would not let staff perform cares due to the severity of her pain level. Staff were educated on the importance of skin checks and alerting the nurse of new wounds.

During an interview, an unlicensed personnel stated the resident's pain increased dramatically one week prior to the resident was hospitalized for her hip fracture stating, "It came out of nowhere. Every time we tried to roll her she would scream in pain." The unlicensed personnel stated staff updated nursing staff each time the resident screamed but stated nursing did nothing other than telling staff to keep administering the resident's prescribed tizanidine.

During an interview, another unlicensed personnel stated she was unaware of the resident's severe pain until the day she worked with the resident stating she became extremely concerned by the amount of pain the resident exhibited. Unlicensed personnel stated she saw a big open wound on the resident's left big toe and observed it was black and blue "like dead tissue." Unlicensed personnel stated the resident appeared scared and appeared to be in a lot of pain. Unlicensed personnel stated the resident's family members stated the resident complained of pain for five days stating, "If she has been complaining of pain for days and nothing has been done about it, obviously what has been done is not working and she needs help."

During an interview, a facility nurse stated she never assessed the resident during the time the resident complained of severe pain stating she read afterhours on-call triage notes and assumed the resident complained of chronic pain, and therefore did not assess her. The nurse stated she may have "missed" the on-call triage note when the resident reported her pain a 10/10. The nurse stated she discontinued the resident's daily wound care two months earlier without a new order from the resident's provider to do so stating an unlicensed staff member told her the resident's wound on her left big toe healed and admitted she never assessed the resident's toe wound. The nurse stated the resident never returned to her baseline status due to hip fracture and pain.

During an interview, a family member stated she and other family members became concerned when they heard the resident yelling and screaming in pain when unlicensed staff attempted to change the resident stating, “I was upset since she never yells like that.”

During an interview, another family member stated the day the resident was hospitalized they removed the resident’s socks and saw a band-aid fall on the floor from the resident’s left sock. In addition, they saw a large, open wound on the resident’s left big toe.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

“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. Resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility conducted an internal investigation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.
cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Centerville City Attorney
Centerville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39268	A. BUILDING: _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA CENTERVILLE	2025 MICHAUD WAY CENTERVILLE, MN 55038

(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: #HL392684840C/#HL392688302M On February 19, 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 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL392684840C/#HL392688302M, tag identification 2310 and 2360.	0 000	Assisted Living Provider 144G. 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.	

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02310	Continued From page 1	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (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 provide appropriate care and services based on the resident's needs for one of one resident (R1) with records reviewed. The licensee's facility failed to address a change in R1's condition after R1 complained of new pain that became severe over several days. R1's family members (FM)-C and FM-D arrived at the facility and called 911. R1 was transported to the hospital and diagnosed with a left hip fracture. In addition, the licensee failed to ensure staff informed the licensed nurse about a new wound on R1's left big toe. 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 May 3, 2023. R1's diagnoses included cerebral infarction	02310		

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02310	Continued From page 2 (stroke), left-sided hemiparesis (paralysis), Type 2 diabetes mellitus, and left neck of femur fracture (hip fracture). R1's service plan dated August 9, 2024, indicated R1 was dependent on staff for medication management, meal preparation, transfers, mobility, toileting, and repositioning. R1 required daily wound care to her left big toe. Care included cleaning toe with wound cleanser, pat dry, apply a thin layer of Bacitracin, and cover with a Band-aid. Staff were to report any changes including increased drainage, fever, redness, pain, or bleeding to nursing staff. R1's assessment dated November 8, 2024, indicated R1 was alert and oriented and able to make her needs known. The resident used an electric wheelchair for mobility and required a full mechanical lift (Hoyer) for all transfers with the assistance of two staff. R1's medication administration record (MAR), dated December 2024, indicated R1 was prescribed as needed (prn) medication for muscle spasms (tizanidine), 2 milligrams (mg), one tablet by mouth up to two times per day. R1's progress note dated December 24, 2024, at 5:18 a.m., indicated unlicensed personnel (ULP) called the afterhours on-call registered nurse (RN) requesting R1's prn tizanidine after R1 reported left arm and hip pain. The on-call RN gave the ULP a verbal okay to administer 2 mg of tizanidine. The ULP was instructed to call back if the tizanidine was not effective in reducing R1's pain. R1's progress note dated December 29, 2024, at 1:49 a.m., indicated the ULP called the afterhours	02310		

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02310	Continued From page 3 nurse after R1 rated her pain 10/10. (The worst pain experienced). The on-call nurse advised ULP to administer R1's tizanidine and requested the ULP obtain a pain score after administering the medication to monitor its effectiveness. R1's record indicated a pain score was never obtained or reported to the on-call nurse. In addition, the on-call nurse never followed up on R1's reported 10/10 pain or updated the resident's provider. R1's progress note Dated December 31, 2024, at 3:27 a.m., indicated R1 complained of pain and spasms in her left arm and leg. The on-call nurse advised the ULP to administer 2 mg of tizanidine requesting the ULP call back if the medication was not effective in reducing the resident's pain. The resident's record lacked documentation the resident's provider was updated. A licensee's communication note dated December 31, 2024, at 3:38 p.m., from licensed practical nurse (LPN)-G to R1's medical provider indicated LPN-G reported, "Staff reports R1 is in a lot of pain even with her prn tizanidine 2 mg. Staff report it is difficult to do cares because she is in so much pain. R1 also requests her prn almost every night. Is there anything we can get her for pain management?" A communication note dated December 31, 2024, at 6:05 p.m., from R1's medical provider to LPN-G, indicated the medical provider asked LPN-G to confirm what prn medication R1 currently used for pain, but LPN-G never responded to R1's medical provider's request. R1's progress note dated January 1, 2025, at 1:01 p.m., ULP-F called the on-call nurse stating R1 told her she had been in a lot of pain since December 27, 2024. ULP-F indicated R1's family	02310		

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02310	Continued From page 4 arrived and removed R1's left sock and saw R1's foot was black and blue with an open wound to R1's left big toe. ULP-F stated R1 screamed in pain and refused to get out of bed since December 28, 2024. ULP-F indicated the wound was not new but a reopened old wound. The on-call RN indicated she would call R1's medical provider and advised ULP-F to administer 2 mg of tizanidine. At 11:27 a.m. the on-call RN left a voice message for R1's medical provider. At 11:35 a.m., R1 and her family decided to call 911. The on-call RN documented, "This RN could hear resident yelling in the background from pain." During the several days R1 reported increased pain, facility nurses never assessed R1 to determine the source of R1's increased pain, implement interventions, monitor the effectiveness of R1's prn muscle spasm medication, or update R1's medical provider. R1's record also lacked evidence the facility nurse was informed and updated on R1's re-opened old wound on the left great toe. R1's hospital record dated January 1, 2025, at 12:22 p.m., indicated R1 was admitted for severe left hip pain lasting several days. R1's left leg was notably swollen. R1 was diagnosed with a closed left hip fracture. FM-C and FM-D questioned why R1's pain was left unchecked for days or why the facility never evaluated her increased pain. R1's wound on her left big toe was red, swollen, and measured 3 centimeters (cm) x 2 cm with no measurable depth. A thin layer of dead tissue (slough) was on the wound with moderate clear drainage and tender to touch. Daily wound care was initiated. A hospital doctor documented, "I have concerns that there was neglect at the facility given the severity of pain, edema	02310		

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02310	Continued From page 5 (swelling) in her leg, and report that this has been going on for days without evaluation." Hospital doctors stated because R1's left hip fracture was 10 days old they were unable to perform surgery on her hip due to the amount of time that passed. On January 7, 2025, R1 was discharged back to the facility and admitted to hospice. R1 was prescribed strong narcotic pain medication upon her return to the facility. R1 never returned to her baseline status and died one month later. During an interview on February 19, 2025, at 1:15 p.m., ULP-A stated R1's increased pain started over a week before R1 was hospitalized stating, "I feel like it happened out of nowhere." ULP-A stated R1 screamed in pain during repositioning, stating she and other ULP told nursing staff but stated nothing was done except to continue to administer R1's prn tizanidine. During an interview on February 24, 2025, at 9:00 a.m., FM-C stated days before R1 was hospitalized she and FM-D became concerned when they heard R1 yelling and screaming when staff attempted to change R1 stating, "I was upset since she never yells like that." FM-C stated days later they checked R1's feet for sores to see if that was the source of R1's pain since R1 was diabetic. FM-C stated she was astonished when she saw a large, open wound on R1's left big toe and her feet were blue, stating ULP must not have checked R1's feet since ULP just dressed R1 for the day. During an interview on February 25, 2025, at 9:00 a.m., FM-D stated prior to calling 911 they removed R1's socks they saw a band-aid from R1's left sock fall on the floor and noticed an open wound on R1's left big toe.	02310		

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02310	Continued From page 6 During an interview on February 28, 2025, at 11:00 a.m., RN-E stated she only worked two days during the time R1 complained of severe pain. RN-E confirmed she never assessed R1 when she complained of severe pain stating she read afterhours on-call triage notes and assumed R1's pain was chronic and therefore, did not assess R1. RN-E stated she may have "missed" the on-call triage note when R1 reported her pain at 10/10. RN-E stated she discontinued R1's daily wound care in October 2024 without assessing it because the ULP told her the wound was healed. RN-E stated R1 never returned to her baseline status due to ongoing pain from her hip fracture. During an interview on March 12, 2025, at 12:00 p.m., ULP-F stated she was unaware of R1's severe pain until January 1, 2025, when she worked with R1, stating she became extremely concerned by the amount of pain R1 exhibited. ULP-F stated she saw a big open wound on R1's left big toe and observed it was black and blue "like dead tissue." ULP-F stated FM-C and FM-D stated R1 had been in severe pain for five days stating, "If she has been complaining of pain for days and nothing has been done about it, obviously what has been done is not working and she needs help." The licensee policy titled Change in Condition, updated May 2024, indicated change in condition evaluations would be initiated whenever a resident experienced a change in condition that was sudden in onset, a marked change in relation to the resident's usual signs and symptoms, or a symptom that was unrelieved by current measures already prescribed. No additional information was provided.	02310		

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02310	Continued From page 7 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		