Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200964462M
Compliance #: HL200965219C

Date Concluded: August 28, 2024

Name, Address, and County of Licensee Investigated:
Northfield Retirement Community
900 Cannon Valley Drive
Northfield, MN 55057
Rice County

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

Evaluator's Name: Deb Schillinger 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 alleged perpetrator (AP), a facility staff unlicensed caregiver, neglected the resident when the resident's plan of care was not followed, resulting in a fall that fractured the resident's hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP did not transfer the resident as directed in the resident's care plan and the resident fell, the error was an isolated incident. The AP at the time of the incident was not assigned to the resident and did not have immediate access to the resident's plan of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, facility internal investigation, facility

incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator made an onsite visit, and observed resident and staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (condition where the heart does not pump blood well enough to meet the body's needs) and debility. The resident's care plan included assistance with transfers, and medication management. The resident's assessment indicated the resident needed transferred with assistance of two unlicensed caregivers and was receiving comfort care with hospice.

The residents medical record indicated the AP was attempting to transfer the resident with a walker when the plan of care was to use a mechanical (Hoyer) lift to transfer the resident. The record indicated the resident had fallen and was lying on the floor complaining of pain in the right hip area. An X-ray later showed the resident sustained a hip fracture, but the decision was to not repair the hip but to continue comfort cares with hospice.

During an interview, a nurse stated the AP would not have had the residents care plan to review on his tablet as he was not assigned to care for the resident on that day. The resident's care plan had been recently updated to transfer with a Hoyer lift from requiring assistance of one caregiver using a walker. The nurse also stated the resident was wanting to try to walk again, and the facility scheduled a reevaluation for the following Monday to assess the resident's ability to walk with the walker.

During an interview, the AP stated he worked every other weekend at the facility. On the day of the incident, the AP was asked to take the resident to her room. The AP stated in previous times he had worked; the resident had transferred using a gait belt and the walker. The AP stated he did not review the resident's care plan that day as he was not assigned to provide care for her and was not aware of the recent changes to her plan of care and did not receive a report at the beginning of the shift that would have included recent care plan changes.

During an interview, a family member stated upon his arrival to the facility the day of the incident, the resident told him she had asked the AP to put the walker in front of her. The AP assisted her to stand and then turned to move the Broda chair. The resident then fell and sustained a fractured hip. The family member stated the AP had relayed the same occurrence of events and was very apologetic. The family member during the same interview stated the resident wanted to walk so badly, she would have taken any opportunity to try to do so. The family member stated the resident has returned to baseline condition or better condition now than at the time of the incident.

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.
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident, the AP was suspended, and retraining was provided.

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
	20096	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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 August 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL200965219C/# HL200964462M. No correction orders are issued.	0 000		