Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201413145M
Compliance #: HL201412050C

Date Concluded: May 28, 2023

Name, Address, and County of Licensee Investigated:
St. Therese Residence
8000 Bass Lake Rd
New Hope, MN 55428-3118
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

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 the resident when the facility failed to check on the resident three times a day per the care plan. The resident fell and laid on the floor for nearly 16 hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it is true the resident fell, the facility had checked on her about an hour prior to finding her on the floor.

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 a review of the resident's records, the facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living unit. The resident's diagnoses included a history of falls and high blood pressure. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, and medications. The resident's assessment indicated she required hand on assistance with transfer and mobility.

Based on the document review, the facility checked the resident's vital signs around 12 noon the day of the fall and provided her assistance with cares around 1:00 p.m. However, the resident's progress notes indicated the resident was found on the floor in her bedroom about 40 minutes later although the actual time of the fall is unknown. A nurse assessed the resident and identified no injuries.

The resident's nurses notes indicated the facility checked the resident's blood pressure three times over the next 40 minutes and found the resident with high blood pressure. Initially the resident refused offer to go to the emergency room, but she did agree to go by 3:30 p.m.

During the interview, the resident stated that she could not remember how she fell. She said the staff came to check on her in the morning and found her on the floor.

During an interview, the family member, on the other hand, stated that she was unsure how accurate the resident's recollection was at the time of the incident. According to the family member, the resident had reported to the emergency physician she had fallen and lay on the floor for 16 hours until the staff found her. The family member also stated the resident had a pendant to call for help, but on this day she did not have it on her.

During an interview, the unlicensed personnel stated that she had been in the resident's room around noon to get her ready for the day. She returned around 2:00 p.m. for a safety check and found the resident lying on the floor. The resident's pendant was found on the table. She immediately notified the nurse.

During an interview, the nurse manager stated she was informed by the nurse a resident had fallen. The resident had no injuries or bruises, but her blood pressure was high. The resident was sent to the hospital for further evaluation due to the high blood pressure. The nurse manager did not know the exact time the resident fell or how long she had been on the floor. She noted that there was no specific time for a safety check unless the resident had a specific request. Safety checks could be done anytime between 6:00 a.m. to 2:30 p.m. for the morning shift and 2:30 p.m. to 10:00 p.m. for the evening shift. The nurse manager confirmed the resident did not have any specific-time request for safety checks other than no one come into her apartment after 10 p.m.

A review of the resident's assessment indicated the safety checks would be done once at 2:00 p.m. and once at 8:00 p.m. The specific request was no check overnight or past 10:00 pm.

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: Not Applicable.

Action taken by facility:
The nurse did an assessment and sent the resident to the hospital for further evaluation.

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
	20141	A. BUILDING: _____ B. WING _____	C 04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE RESIDENCE	8008 BASS LAKE ROAD NEW HOPE, MN 55428

(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 April 3, 2023, the Minnesota Department of Health initiated an investigation of complaint HL201412050C / HL201413145M. No correction orders are issued.	0 000		