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 #: HL20257003M
Compliance #: HL20257004C

Date Concluded: January 12, 2023

Name, Address, and County of Licensee Investigated:
Assisted Living at North Ridge
5500 Boone Avenue
Minneapolis, MN 55428
Hennepin County

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

Evaluator's Name: Paul Spencer, 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 identify and assess a decline in the resident's status leading to a delay in treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility checked on the resident multiple times and, when he showed a decline, sent him the emergency room (ER).

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included a review of the resident's facility and hospital medical records.

The resident lived in an assisted living facility. The resident's diagnoses included chronic kidney disease. The resident's service plan included indicated the resident was independent with most cares and made decisions independently, however the facility provided medication management.

The resident's progress notes indicated two nurses checked on the resident because he was usually independent with dressing but remained undressed at about 3:00 p.m. The resident stated he was fine and asked them to leave his apartment. The same document indicated one of the nurses returned at 5:00 p.m. and the resident remained undressed but again he asked the nurse to leave his apartment.

The resident's incident form indicated an unlicensed caregiver entered the resident's room at 8:00 p.m. and found the resident undressed and on the floor. When the resident spoke, she could not understand what he was saying, which was a change for the resident. The resident handed the unlicensed caregiver the phone and 911 was on the line. The resident then transferred to the ER.

The resident's hospital records indicated the resident's diagnoses included acute respiratory failure, which required intubation (a tube placed in the resident's airway to assist with breathing). The same documents indicated the resident began dialysis treatment because his kidney disease had progressed. The same documents indicated the resident received both physical and occupational therapy and returned to the facility with the plan to continue dialysis.

During an interview with the nurse who saw the resident at both 3:00 p.m. and 5:00 p.m., the nurse stated the resident was able to communicate clearly. The nurse stated it was not unusual for the resident to ask staff members to leave if he did not need anything.

During an interview, one of the unlicensed caregivers who saw the resident at 8:00 p.m. stated the resident was found on the floor and covered with a sheet. She stated she and her co-worker updated the on-call nurse and helped send the resident to the ER.

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: Attempts to interview the resident were unsuccessful.
Family/Responsible Party interviewed: Attempts to interview the family were unsuccessful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
As described in the report, the facility checked the resident multiple times during the period prior to the resident's hospitalization.

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
	20257	A. BUILDING: _____ B. WING _____	C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH 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 Initial comments On December 14, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL20257003M/ #HL20257004C. No correction orders are issued.	0 000		