Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202575324M
Compliance #: HL202579257C

Date Concluded: March 31, 2023

Name, Address, and County of Licensee Investigated:
North Ridge Assisted Living
5500 Boone Ave North 18
New Hope, MN 55428
Hennepin County

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

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP) abused a resident when they repeatedly pinched the resident's left inner thigh causing the resident to scream out in pain resulting in a large dark purple bruise from the resident's left inner knee to her groin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although the resident consistently reported the AP pinched her, it could not be determined the cause of the resident's bruising.

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 medical record, photographs of the bruising, the facility incident report, facility investigation, staff interviews, staff schedules, personnel files, disciplinary records, education, training, and facility policies and procedures. Also, the investigator observed the resident's room, cares provided to the resident, and the resident's lump and bruising.

The resident resided in an assisted living facility secure memory care unit with diagnoses including vascular dementia, and senile degeneration of the brain. The resident's assessment indicated she was cognitively impaired, oriented to self only, and utilized hospice services for end-of-life care. The resident required the assistance of two staff and a mechanical standing lift for transfers.

A facility incident report indicated the resident had a lump with dark purple bruising spreading from her left knee to the groin. The report indicated the resident stated the AP got mad and pinched her. The incident report indicated no environmental factors, or incidents had been reported that could have caused the bruise.

A facility investigation report indicated the resident stated, "A night shift aide (AP) pinched her because she (AP) was mad, she (resident) screamed out in pain, and the aide (AP) pinched her again harder". The investigation indicated the resident had a large painful lump on her left inner thigh, just above the knee, that was warm to the touch, with bruising from the resident's knee to groin. Staff interviewed who cared for the resident the previous day, denied seeing any bruising on the resident. When interviewed the AP stated she heard the resident screaming and found her climbing out of bed. The AP stated she provided incontinence care, repositioned the resident, but saw no bruising. The facility investigation indicated the appearance of the resident's lump and bruising did not align with the resident being pinched repeatedly.

An after-visit summary indicated the resident was seen for post incident bruising. When questioned the resident stated the AP was mad and pinched her. The resident refused a physical examination of the area, so the provider reviewed photographs which showed a large area of bruising on the resident's inner left thigh. At the time of the examination, the cause of the lump and bruising could not be determined.

During an interview, facility staff stated the resident had a hard lump just above the left knee that was warm to the touch, and painful. Staff stated the lump appeared to be getting larger.

One month after the incident, the investigator observed staff providing care to the resident. The investigator observed a smooth oval shaped encapsulated lump with dark yellow green discoloration on the skin. The lump appeared like a fluid filled balloon under the resident's skin. The resident stated the lump was not painful.

During an interview, facility leadership staff stated they were not able to determine the cause of the resident's lump or bruising. Leadership staff stated although the resident's bruising was extensive, there were no defined pinch marks of bruising on the resident's left thigh. The leadership staff stated the resident's lump and bruising was not likely caused by the AP pinching the resident. Leadership staff stated the resident's provider had not evaluated the lump.

When interviewed the AP denied pinching the resident.

In conclusion, it was inconclusive if abuse occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Physical Abuse: Minnesota Statutes, section 260E.03, Subd. 18
"Physical abuse" means any physical injury, mental injury under subdivision 13, or threatened injury under subdivision 23, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.
(b) Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian that does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582.
(c) For the purposes of this subdivision, actions that are not reasonable and moderate include, but are not limited to, any of the following:
(1) throwing, kicking, burning, biting, or cutting a child;
(2) striking a child with a closed fist;
(3) shaking a child under age three;
(4) striking or other actions that result in any nonaccidental injury to a child under 18 months of age;
(5) unreasonable interference with a child's breathing;
(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
(7) striking a child under age one on the face or head;
(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;
(9) purposely giving a child:
(i) poison, alcohol, or dangerous, harmful, or controlled substances that were not prescribed for the child by a practitioner in order to control or punish the child; or
(ii) other substances that substantially affect the child's behavior, motor coordination, or judgment; that result in sickness or internal injury; or that subject the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining.

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

Action taken by facility:
The facility reported the resident's injuries, suspended the AP pending investigation, investigated the incident, and reported to the Minnesota Adult Abuse Reporting Center timely.

Action taken by the Minnesota Department of Health:
No actions 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 03/20/2023

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 On March 20, 2023, the Minnesota Department of Health initiated an investigation of complaint HL202575324M/HL202579257C. No correction orders are issued.	0 000	g 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 surveyors' 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 subd. 1, 2, and 3.	