Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202576243M
Compliance #: HL202571923C

Date Concluded: October 2, 2023

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

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

Evaluator's Name:
Katie Germann, 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), facility staff, abused a resident when she pushed the resident into her bed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident stated the AP pushed her into bed when assisting the resident to transfer. The AP stated she did not push the resident. The allegation does not rise to the level of abuse.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of medical records, a facility investigation of the incident, employee files, and facility policies and procedures. Also, the investigator observed staff providing cares to residents.

The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder. The resident's service plan included assistance with bathing, dressing, grooming, meals, medication administration, and transferring. The resident's assessment indicated the resident had an increased risk of falling and required assistance of staff to transfer.

Nursing progress notes indicated the AP gave the resident a shower and brought the resident back to her room. The AP was assisting the resident to transfer and told the resident to stand up straight when she was using her walker. The resident told the AP she was not able to stand up straight and the AP pushed the resident into her bed. The resident stated she was scared and laid in her bed shaking. The note indicated the resident did not ask for further assistance because she was scared. The resident stated she landed on her hip on the bed, and it was painful. The note indicated the resident had no bruising, swelling, or redness.

During an interview the facility nurse stated the resident was brought to her office by another staff member the day after the incident. The resident stated said she had a really good shower the night before, but after the shower, the AP was assisting her to bed and told the resident to stand up straight. The resident said she was unable to stand up straight and the AP pushed the resident into bed. The facility nurse stated when the AP was asked if she pushed the resident into bed the AP denied the incident occurred.

During an interview the resident stated the AP wheeled her to her bed in her wheelchair and asked her to stand up using her walker. The resident stated she stood up, but the AP told her to stand up straight. When the resident told the AP she could not stand up straight, the AP grabbed her under her shoulders, picked her up from behind, and threw her on the bed. The resident stated she was scared, but not hurt and she was left comfortable in her bed. The AP did not say anything to the resident and left the room.

During interview the facility administrator stated the resident has told the same story multiple times to multiple people. The administrator stated when facility administration interviewed the AP, she did not deny the resident's story.

During interview the AP stated she assisted the resident to shower and brought the resident to her room in the wheelchair. The resident told the AP she wanted to go to bed so the AP assisted the resident into her bed. The AP stated she never pushed the resident and only told the resident she did not want her to fall.
In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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

Action taken by facility:
The AP no longer works for the facility.

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 08/23/2023

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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL202573946C/ #HL202577384M #HL202575062C/ #HL202578024M #HL202571923C/ #HL202576243M On August 23, 2023, 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 121 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL202573946C/ #HL202577384M, and #HL202575062C/#HL202578024M tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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 08/23/2023

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
02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of two residents (R1 and R2) were 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		