Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202577384M
Compliance #: HL202573946C

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: Substantiated, facility responsibility

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 facility neglected a resident when the resident left the locked memory care unit and walked outside unsupervised. The resident fell on the sidewalk, causing a laceration (cut) on the resident's face and fractures in her right wrist.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident left the locked memory care unit and went outside the facility front doors. The resident was found outside on the sidewalk by people who were driving by. The resident cut her chin and sustained a right radius and ulnar styloid (wrist) fractures. Staff did not know how the resident was able to leave the locked facility. The residents record contained no documentation the resident had been checked on by staff the day of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and the police. The investigation included review of medical records, hospital notes, police report, photographs of incident, staff schedules, door alarm manual, facility investigation, nursing progress notes, and aide task lists. Also, the investigator observed staff cares of residents and the facility locked memory care door.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with dressing, bathing, grooming, toileting, meals, medication administration, housekeeping, and laundry. The resident's assessment indicated the resident had a high risk of falling and required assistance with ambulation for safety.

A police report indicated the police dispatch received a call at 2:03 p.m. from a witness who found the resident lying on the ground outside of the facility. Upon arrival on the scene, the resident was sitting on the sidewalk outside of the facility with unlicensed staff, who was holding a face mask to the resident's face to help control bleeding. The resident had blood on her clothing and there was blood on the sidewalk where the resident had fallen. The police report indicated facility staff informed the officer the resident lived on a locked memory care unit. The door to the memory care unit had a 10-second delay before locking after anyone entered or exited the door. The resident's unlicensed staff reported she assisted the resident to the bathroom between 1:30 p.m. and 1:35 p.m. After assisting the resident, the staff left the resident's room and closed the door. At approximately 1:50 p.m., the staff noted the resident's apartment door was open and she was unable to locate the resident. The staff informed her coworker on the unit, and they performed a head count. While looking for the resident, the staff found out the resident was outside. The staff stated she did not know how the resident was able to leave the locked unit but thought another staff was the last person to go through the door. The police report indicated the unlicensed personnel who used the locked memory care door last reported she entered the unit at approximately 1:48 p.m. and left the unit at approximately 2:00 p.m. The staff stated she had not seen the resident leave the unit either time she went through the door. When the staff left the locked unit, she went to the front desk to speak with one of the facility administrators. The report indicated the facility administrator stated she never saw the resident walk by her while she was near the front desk. The resident was transported to the hospital for further evaluation.

Photos of the incident showed the resident bleeding from a large laceration on the left side of her face. There was blood on the resident's shirt and on the sidewalk outside of the facility.

Hospital notes indicated the resident had a laceration on her left chin and sustained a right radius and ulnar styloid (wrist) fractures from her fall. The resident was released from the hospital five days later with physician orders to receive physical and occupational therapy.

A facility investigation of the incident indicated it could not be determined at what point the resident was able to leave the locked facility. None of the staff interviewed in the internal investigation had seen the resident after approximately 12:00 p.m. The staff working at the front desk indicated in a written statement she was busy with phone calls and did not see the resident walk past the front desk and outside. The administrative staff covering a break at the front desk stated in a written statement she saw the resident and her son enter the building after an appointment at approximately 11:45 a.m.-12:00 p.m. and did not see the resident after.

The staff documentation for the resident on the day of the incident indicated the resident received assistance with meals at 12:01 p.m. There was no documentation indicating if the resident received staff assistance with toileting and if safety checks were completed on the day of the incident.

During interview the unlicensed staff stated she assisted the resident to the bathroom and after the resident was finished, she left and closed the resident's door. The staff stated she went to assist another resident in the room across the hall. The staff stated when one staff is providing cares in a resident's room, the other staff are on the unit monitoring the other residents and the locked door. On the day of the incident, another unlicensed personnel who does not work in memory care brought another resident back to memory care from an activity. The staff asked for assistance to toilet the other resident so the other staff who was working on the unit went to help them. When the staff was done with cares across the hall, she noticed the resident's door was open and could not see the resident. The staff alerted her coworker on the memory care unit, and they began looking for the resident. They saw the resident on the sidewalk through the window and they ran outside to assist.

In an interview with the other staff working on the unit, she stated she saw the resident in the dining room with another resident. She was sitting at the nurse's station when another staff member brought a resident back to the unit after an activity and asked for help toileting the other resident. The staff assisted the resident to the toilet and afterwards her coworker informed her she could not find the resident. They began looking for the resident and saw her through a window outside surrounded by other staff members.

During an interview, another staff stated she had escorted another resident to the unit after an activity outside of the unit around the time the resident left the unit. She stated when she entered the unit, she waited for the door to latch and click (indicated the door was locked). She assisted the resident to his room and then left the unit. The staff stated when she left the unit, she stood on the other side of the door and waited, saying the ABCs to herself before she left and went to the front desk, which is located near the locked unit. The staff stated she never saw the resident on the unit or near the door.

During interview the facility nurse stated there was no specific plan assigned to caregivers to check on the resident or assigned times to provide cares or toileting. The nurse stated it was an expectation staff rounded on the resident every two hours.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: No, due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility posted signs on the locked unit doors reminding staff to ensure residents were unable to exit the locked unit. The facility also educated staff on how to properly use locked doors and ensuring only staff working on the unit were allowed in the locked units.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
New Hope City Attorney
New Hope Police Department

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		

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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		