*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL205512907M
**Compliance #:** HL205514905C

**Date Concluded:** June 30, 2023

**Name, Address, and County of Licensee Investigated:**
Woodbury Estates
2825 Woodlane Drive
Woodbury MN
Ramsey County

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

**Evaluator's Name:** Maggie Regnier 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 facility neglected the resident when he fell and later it was determined he suffered fractured ribs.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. While the resident did fall, the facility immediately assessed the resident and notified the provider and orders for over-the-counter pain medicine was given. The resident continued to have 5 out of 10 pain and the provider was again notified. Orders for portable x-rays were received and the resident did have the x-rays the result of those x-rays were negative for fracture and the facility and provider were made aware of that.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident who is his own person and was able to be interviewed. The investigation included review of medical records,

resident records, facility records including incident reports, falls reports, staffing records and policies related to falls, medication administration, provider notification and staff training. Also, the investigator observed staff to staff interactions and staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included abnormal gait with frequent falls, tremors, pulmonary disease, and chronic obstructive pulmonary disease. The resident's service plan included assistance with meals and medication management. The resident's assessment indicated he needed little assistance with activities of daily living including dressing and eating. The resident used a walker for ambulation and at times used a wheelchair for mobility.

The resident's progress notes indicated the resident was in the dining room and fell. The same document indicated he said he tripped and fell. A registered nurse assessed him and found the resident complained of left upper back pain, so the nurse called the medical provider who directed acetaminophen for pain as needed and to monitoring for concerning symptoms.

Four days later, the resident's progress notes indicated the licensed practical nurse found the resident continued to have left back pain and the facility updated the medical provider. The medical provider ordered schedule acetaminophen for one week, X-ray of the resident's left mid-back, and a gel pain reliever four times a day as needed.

The next day the medical provider assessed the resident for the left back pain and reiterated the plan to address his pain. The X-ray results came back the same day and indicated no fractures.

About two weeks after the resident fell in the dining room, he tested positive for COVID and was sent to the hospital. The hospital completed a chest X-ray which showed four rib fractures.

During an interview, an unlicensed staff member said the resident rarely complained of pain or discomfort and did remember him telling her about the fall, but he did not mention his back pain

During an interview with the registered nurse stated she notified the provider and obtained the orders.  The registered nurse stated the resident rarely complained of pain and reported the acetaminophen controlled his pain.

During an interview with the resident stated the facility took great care of him and felt they did everything right when he fell. He also stated the kept following up and informed the provider when needed. He does not know why the initial x-rays did not show a fracture but also stated it was nobody's fault and these things happen.

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**: No, attempted but no return call.
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
The facility assessed the resident initially after the fall and then continued to reassess. throughout the holiday weekend. The staff also gave the pain medication as ordered. The staff communicated with the providers thought out this time.

**Action taken by the Minnesota Department of Health:**
No further action 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 |
|---|---|---|---|
| | 20551 | A. BUILDING: _____ B. WING _____ | C 05/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODBURY ESTATES | 2825 WOODLANE DRIVE WOODBURY, MN 55125 |

| (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<br><br>On May 17, 2023, the Minnesota Department of Health initiated an investigation of complaint # HL205513107M/#HL205515160C and HL205512907M/# HL205514905C . No correction orders are issued. | 0 000 | | |