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 #: HL208469707M
Compliance #: HL208467611C

Date Concluded: April 4, 2024

Name, Address, and County of Licensee Investigated:
New Journey Residence
303 Hat Trick Avenue
Eveleth, MN 55734
St. Louis County

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

Evaluator's Name: Barbara Axness, 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 staff failed to implement interventions after the resident sustained multiple falls and fractured her hip. The resident was admitted to hospice for comfort cares. In addition, the facility failed to reassess the resident for a change in condition after she tested positive for COVID-19.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident sustained multiple falls and a hip fracture, the facility assessed, monitored, and implemented new interventions following each fall. In addition, facility staff monitored the resident's condition after she tested positive for Covid-19.

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

medical record, facility records, and hospital records. Also, the investigator observed care and services in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included memory impairment, osteoporosis (a condition when bone strength weakens and is susceptible to fracture), and hypertension (high blood pressure). The resident's service plan included assistance with hourly safety checks, dressing, grooming, bathing, and medication administration. The resident's assessment indicated the resident was at risk for falls but did not identify a significant history of falls. The resident was independent in her room, but required assistance with walking long distances.

Facility records indicated the resident fell three times over a two-week period, which was unusual for the resident. After the first two falls, the facility implemented interventions to prevent additional falls. The resident tested positive for COVID-19 after the second fall, however, symptoms remained mild and the resident did not have any significant changes to her baseline health status that would warrant the registered nurse to conduct a change in condition assessment. The third time the resident fell, facility staff contacted the on-call registered nurse and sent the resident to the emergency room after the resident was not able to move normally. Incident reports were completed after each fall and the facility routinely reviewed fall trends and set goals for reducing overall falls in periodic quality improvement meetings.

Hospital records indicated the resident was diagnosed with a right intertrochanteric fracture (a break in the right thigh bone) after falling at the facility. The resident later discharged to a skilled nursing facility.

During an interview, the facility nurse stated the resident was independent with walking in her room and was not someone who fell often. The nurse stated that interventions were put in place such as a visual reminder for the resident to use her walker, and leaving the blinds open in her room, so staff could see if she was walking without her walker. The nurse stated staff immediately contacted the nurse after the third fall and after management's review of the incident, they determined the resident's plan of care was followed at the time of the fall. The nurse stated after the resident tested positive for COVID-19, she seemed a little more forgetful but did not experience any significant change in condition.

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 were not successful.
Family/Responsible Party interviewed: Attempts to interview were not successful.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

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
	20846	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW JOURNEY RESIDENCE	**303 HAT TRICK AVENUE EVELETH, MN 55734**

(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 27, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL208469707M/#HL208467611C. No correction orders are issued.	0 000		