Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL281253301M
Compliance# HL281254302C

Date Concluded: October 30, 2024

Name, Address, and County of Licensee Investigated:
Loren on Park
2625 Park Avenue
Minneapolis, MN 55128
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, 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 provide supervision to ensure resident was not smoking inside the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided on going education to the resident and family about the facility policy involving smoking on the premises, cessation techniques, and made continued adjustments to the resident's the care plan. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, facility internal investigation documentation, staff schedules, and facility policies and procedures. The investigator also toured the facility and observed staff interacting with residents.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, major depressive disorder, and nicotine dependence. The resident's service plan included assistance with activities of daily living, housekeeping, medication administration, and safety checks. The resident's assessment indicated the resident's cognition was intact and she required assistance with daily management of nicotine addiction.

Facility documentation indicated the resident was non-compliant with the facility's no smoking policy. On more than one occasion staff witnessed the resident smoking cigarettes in her apartment. One morning, staff entered the resident's room to investigate a burning smell and saw a couch cushion was burning in the resident's living room. Emergency services were notified, and the local fire department assisted with the incident.

During an interview, the resident stated that she remembered an incident where the fire department came because a couch cushion started on fire. Following the incident, her cigarettes were moved and stored in an administration office located near the main entrance. The resident stated she was aware of the no smoking policy and knew the locations of designated smoking areas outside of the building.

During an interview, a family member recalled being informed of the incident with the resident's couch but could not confirm the damage as it was removed by the fire department. The family member stated a care conference was held with the resident after the incident. The facility reiterated the no smoking policy, provided assistance with smoking cessation techniques, and increased observation and safety checks on the resident. The family member had no other concern of the care the resident has received.

During an interview, a case manager stated there was a care conferences at the facility about the ongoing violation of the smoking policy but had no additional concerns with the care provided at the facility.

During investigative interviews, multiple staff members stated they have been instructed by facility administrative and nursing staff to increase observation of the resident due to the frequency of smoking violations and to report any suspicion of the resident violating the smoking policy.

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: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility collaborated with case management and family members to educate the resident on the possible consequences of smoking violations.

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
	28125	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOREN ON PARK	2625 PARK AVENUE MINNEAPOLIS, MN 55407

(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 October 23, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL281254302C /#HL281253301M. No correction orders are issued.	0 000		