Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL285133365M
Compliance #: HL285133548C

Date Concluded: August 25, 2024

Name, Address, and County of Licensee Investigated:
Oak Terrace Senior Housing
622 Aberdeen Ave
Jordan, MN 55352
Scott County

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

Evaluator's Name: Lena Gangestad, 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 the resident was found on the floor surrounded by blood. She was admitted to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did fall and require hospitalization, the resident had not had recent falls and the facility put additional falls prevention interventions in placed after this fall. The resident returned the same day from the hospital after evaluation and treatment.

The investigator conducted interviews with administrative staff, and family member. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses included dementia. The resident's service plan included assistance with all activities of daily living which included two person physical assistance with transfers and bed mobility. The service plan also indicated she needed to be checked and repositioned every two hours. The resident was on hospice services.

One evening, another resident went to visit and found the resident on the floor next to her bed. She had hit her head and was sent to the emergency room (ER) for evaluation due to the head injury.

The internal investigation report indicated the resident had been placed in bed, centered in the room, with a fall mat on the ground to the left and a body pillow on the right for positioning. Staff members had checked on the resident at 1:10 p.m. and the resident was discovered on the floor at 2:40 p.m. The internal investigation included a hand-drawn diagram which indicated the resident fell off the right side of the bed along with the body pillow.

Hospital records indicated the resident had a computed tomography (CT) scan done and it showed a brain bleed on the side where she hit the floor and another brain bleed on the opposite side. The physician decided to repeat CT scan 4 hours later, which showed the bleeding had not worsened. The same records indicated she received 8 stitches above her right eye, 2 stitches below that, and other areas were glued due to skin tears. Additionally, she had a large abrasion on her right shoulder. The hospital discharged her back to the facility the same day.

During an interview, a family member stated she was notified about the fall and the resident was taken to the hospital. She said the resident had a minor brain bleed, along with a few cuts and a skin tear on her temple. She also said the resident was on hospice care and was supposed to be checked every two hours.

During an interview, a manager stated the staff members who worked that evening had checked on the resident and assisted her with toileting around 1:10 p.m. They then put her back to bed, and the fall mat was in place. The manager said that when she interviewed the staff, they told her they had lowered the bed, but there were unsure whether it was in the lowest position the bed could go. At the time, the bed was not against the wall which had been discussed per the family's request but had not been implemented.

A review of the resident's medical record indicated the facility added a note to her service record to ensure the bed was at its lowest level following this fall. A review of the resident's medical record did not identify recent falls prior to this incident.

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: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reported the case to the Minnesota Adult Abuse Reporting Center and initiated an internal investigation. The service plan was updated, and re-education was provided to all staff.

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
	28513	A. BUILDING: _____ B. WING _____	C 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HOUSING OF JORDAN	622 ABERDEEN AVENUE JORDAN, MN 55352

(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 June 18, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL285133365M/HL285133548C and #HL285132242M/HL285131208C. No correction orders are issued.	0 000		