Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL288876145M
Compliance #: HL288871600C

Date Concluded: August 8, 2023

Name, Address, and County of Licensee Investigated:
The Landmark of Fridley
6490 Central Avenue Northeast
Fridley, Minnesota 55432
Anoka County

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

Evaluator's Name: Nicole Myslicki, 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 fell and sustained multiple fractures. Subsequently, the resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility completed rounds on the resident, followed her plan of care, and called 911 after finding her on the floor.

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, fall incident reports, and policies including vulnerable adult, adverse events, and rounding on residents. The investigation also included review of the resident's hospital medical records and death certificate. Also, the investigator observed staff interactions with residents, toileting, and medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and osteoporosis. The resident's service plan included assistance with transfers, safety checks, and incontinence care. The resident's assessment indicated the resident used a wheelchair and required assistance with transfers due to recently breaking her leg, being unsteady on her feet, and impaired memory.

An internal investigation indicated staff found the resident unresponsive on the floor, lying on her back next to her bed. The resident's vitals signs were taken, and staff called 911. The resident's neck appeared slightly displaced. Staff found the resident on the ground approximately one and a half to two hours after the last time she checked on the resident.

Hospital records indicated the resident sustained multiple fractures and may have experienced a heart attack. The resident remained in the hospital on palliative care for four days before dying.

The death certificate identified the resident's cause of death as complications of multiple blunt force injuries due to a fall.

During an interview, an unlicensed personnel (ULP), stated she had delivered laundry to the resident's room and checked on the resident earlier. At that time, the resident remained in bed. Later, when the ULP went to check on the resident again, she walked into the resident's room, and the resident laid on the floor. ULP notified the nurse on duty came to assist.

During an interview, a nurse stated the resident had a history of falls, even prior to living at the facility. The resident would transfer herself often. Most of the time prior to her death, the resident used a wheelchair but would come out of her room walking without assistance or a walker. In memory care, residents did not have call lights, but staff completed hourly rounds. The nurse stated she completed an internal investigation of the fall and thought was just an unfortunate incident. A staff member had been completing rounds and found the resident on the floor. Due to the resident being impulsive, sometimes staff could not catch her before her attempt to self-transfer. The nurse stated none of the staff on duty heard the fall.

During an interview, the resident's family member stated the resident had a history of falls at this facility and her previous facility, some of which resulted in broken bones. The resident would try to get up without assistance. The family member stated the facility did the best they could in the situation. The resident never expressed feeling unsafe or that her needs were not being met at the facility.

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 is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital and completed an internal investigation.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28887	A. BUILDING: _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDMARK OF FRIDLEY	6490 CENTRAL AVENUE NE FRIDLEY, MN 55432

(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: #HL288871600C/#HL288876145M On June 8, 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 70 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for ##HL288871600C/#HL288876145M, tag identification 0460.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one residents (R1) had a system in place to request assistance 24 hours per day, seven days per week. This had the potential to affect all residents within the memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 460		

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0 460	Continued From page 2 R1 admitted to the licensee April 25, 2022. R1's diagnoses included dementia and osteoporosis. R1's service plan dated April 19, 2023, indicated R1 received assistance with toileting, transfers, and safety checks. R1's nursing assessment dated March 12, 2023, indicated R1 had a history of falls and fractures. This nursing assessment also indicated R1 had balance problems while standing and walking. An internal investigation dated April 15, 2023, indicated staff found R1 on the floor unresponsive around 5:30 a.m. The nurse assessed the resident for injuries, checked vital signs, and called 911. Hospital medical records dated April 15, 2023, indicated R1 remained in the hospital until she died on April 19, 2023. R1's death certificate indicated R1 died from complications of multiple blunt force traumas from a fall. During an interview on July 6, 2023, at 11:02 a.m., director of nursing (DON)-A stated memory care residents did not have call light pendant. Apartments had motion lights, but not call lights. DON-A stated if a resident needed a pendant, the licensee would provide one. DON-A stated R1 would not have remembered to push a call light pendant with her impulsivity and cognitive status. Instead of the call light system, staff were to complete customer service rounds hourly. The licensee lacked a policy addressing this requirement in accordance with Minnesota Statutes 144G.	0 460		

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0 460	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) Days	0 460		