Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302172361M
Compliance #: HL302174062C

Date Concluded: June 29, 2023

Name, Address, and County of Licensee Investigated:
Arbor Garden Place
535 Canyon Drive NW
Eyota, MN 55934
Olmsted County

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

Evaluator's Name: Julie Serbus, 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 in his room kneeling with upper body resting on the seat of a chair with chest pain after an apparent unwitnessed fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility discovered the resident on the floor with injuries. The facility responded appropriately by contacting 911 and sent the resident to the emergency room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of resident incidents, emergency room summaries, individual abuse prevention assessment, progress notes, and nursing reviews. Also, the investigator observed facility staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis, hypertension, osteoarthritis of the hip, and abnormalities of gait and mobility. The resident's service plan included assistance with medication administration, staff to provide cues for use of walker, assistance with showers and dressing. The resident's assessment indicated cognitive decline and falls.

The resident's progress notes indicated facility staff entered the resident's room to give him his morning pills and found him kneeling in front of a chair in his bedroom with his upper body on the seat of the chair with his face down. The resident complained of chest pain and a bruise around his right eye. The resident also had increased confusion. The facility staff contacted 911 and transferred him to the emergency room.

During an interview, facility nurses stated the resident was experiencing cognitive decline and was on fall protocols due to history of falls with injuries. The resident refused assistance from staff regarding showers and dressing. Wellness checks were completed multiple times throughout the day including during mealtimes, daily when he would visit his wife in memory care, and during medication administration times.

During interviews, multiple unlicensed personnel (ULPs) stated the resident had become more forgetful and wandered on overnights. The resident was found in his bedroom apartment the morning of the incident with his walker located in the bathroom. The resident was not able to give an accurate description of what had happened as his speech was incoherent stating he did not fall and then stating he fell.

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
Family/Responsible Party interviewed: No, but provided information through email
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility staff, per facility protocol, contacted licensed nurse immediately when finding resident on the floor.

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
	30217	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GARDEN PLACE	535 CANYON DRIVE NW EYOTA, MN 55934

(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 28, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL302174062C/#HL302172361M and #HL302174063C/#HL302172362M. No correction orders are issued.	0 000		