Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302172362M
Compliance #: HL302174063C

Date Concluded: June 29, 2023

Name, Address, and County of Licensee Investigated:
Arbor Garden Place
535 Canyon Dr 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 they found the resident sitting on the floor next to the bed resulting after an unwitnessed fall. The resident sustained a non-operative hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident used a walker for ambulation and while in her room would be noncompliant and use furniture to steady herself and not the walker.

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 facility progress notes, incident reports, and service plan. During an onsite visit, the investigator observed staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included mild cognitive impairment and hypertension. The resident's service plan included assistance with medication administration, bathing, verbal cues for dressing, and use of a two-wheeled walker for ambulation.

The resident's progress note indicated staff entered the resident's room for morning rounds and found the resident on the floor near her bed. The resident complained of not feeling well and vital signs confirmed a fever. The resident denied injury or pain and range of motion was normal. The same document indicated the nurse was notified, directed staff to monitor resident. When the nurse arrived, she tested the resident for COVID, which was positive along with low oxygen levels. The facility transferred the resident to the emergency department (ED) for evaluation.

During an interview, facility nurses stated the resident verbalized not feeling well and tested positive for COVID on the morning of the incident. The nurses stated the resident has poor memory and required constant reminders to use her walker for ambulation due to her unsteady balance. The resident was transferred to the hospital for evaluation where x-rays identified the resident had a non-operable hairline hip fracture. Physical therapy evaluated resident and could bear weight as tolerated with no restrictions.

During an interview, the family member stated the resident wants to be independent and do things for herself along with having her own routine. The family member stated the resident says the staff reminds her to use the walker for safety. The family member stated the resident has a high pain tolerance and had a history of falls with injuries.

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: Yes
Alleged Perpetrator interviewed: Not Applicable

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		