Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30625001M
Compliance #: HL30625002C

Date Concluded: January 4, 2023

Name, Address, and County of Licensee Investigated:
Northern Oak Place
(formerly The Landings of Blaine)
1005 Paul Parkway
Blaine, MN 55434
Anoka County

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

Evaluator's Name: Paul Spencer, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 was left lying on the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident fell, the facility appropriately assessed and sent the resident to the emergency room.

The investigator conducted interviews with facility nursing staff involved in the resident's cares at the time. The investigation included review of the resident's medical records including documents from the ER.

The resident resided in the assisted living facility. The resident's diagnoses included dementia and rheumatoid arthritis. The resident's service plan included assistance with transfers to the

bathroom, escorts to meal while using a walker or wheelchair, medication management, and supplemental oxygen.

The resident's progress notes indicated the unlicensed personnel (ULP) did a routine check and found the resident on the floor. The same document indicated the resident said she tried to pick something up off the floor when she fell. While the ULP attempted to get a set of vital signs, the resident asked to go the hospital, so the ULP called 911 and the resident went to the emergency room. The ULP updated the registered nurse and left a message with a family member.

The resident's emergency room notes from the same day indicated the resident arrived with right hip pain, which resolved with one dose of pain medication. The same document indicated the emergency room identified no acute injuries, found no need for admission to the hospital, and sent the resident back to the facility.

About five days later, the resident's progress notes indicated the resident fell again. When the ULP found the resident this time, the resident stated she was reaching for something on the floor. The same document indicated the resident's supplemental oxygen tubing was not in place and her oxygen saturations were 88% although the care planned goal was 90% or higher. The ULP updated the registered nurse and a member of the resident's family. The ULP called 911 and sent the resident to the emergency room.

The resident's emergency room notes from this day indicated she had a bump on the back of her head, but no other acute injuries were identified so the resident returned to the facility.

The resident's progress notes indicated the emergency room contacted the facility she was returning. The same document indicated the emergency room nurse commented the resident did not like to wear her oxygen.

About three weeks later, the resident's progress notes indicated the resident's two falls prompted a review and adjustment of her blood pressure medications. The same document indicated no further falls had occurred.

During an interview, the registered nurse stated the facility contacted her on both occasions when the resident fell and sent her to the emergency room. The registered nurse stated she completed the resident's assessment later and recalled the resident made her own decisions independently.

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

Action taken by facility: As described above in the report.

Action taken by the Minnesota Department of Health:
No further action 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
	30625	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN OAK PLACE	1005 PAUL PARKWAY NE BLAINE, MN 55434

(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 Initial comments On December 7, 2022, the Minnesota Department of Health initiated an investigation of complaint HL30625001M/ /#HL30625002C. No correction orders are issued.	0 000		