Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306683501M
Compliance #: HL306683766C

Date Concluded: August 6, 2024

Name, Address, and County of Licensee Investigated:
Tamarack Court of Bemidji
1511 Delton Avenue NW
Bemidji, MN 56601
Beltrami County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP), a facility staff member, neglected the resident when she failed to complete scheduled safety checks per the resident's service plan. The resident fell and was admitted to the hospital with a subdural hematoma (bleeding in the brain).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident's service plan was not followed, it was unable to be determined if the resident's fall and injury were a direct result of staff's failure to implement the service plan. Following the fall, nursing staff monitored the resident and when a change in condition was observed, the resident was sent to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, hospital records, facility internal investigation documentation, facility incident reports,

personnel files, staff schedules, and related policies and procedures. Also, the investigator observed care and services provided in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included a history of stroke with left-sided weakness. The resident's assessment indicated the resident was at risk for falls. The resident's service plan included assistance with dressing, grooming, bathing, transfers, behavior management, toileting assistance every four hours, and every two-hour safety checks.

The day the incident occurred, the resident was found on the floor of his bathroom at 5:30 a.m. with a skin tear on his back, bruising and redness to his shoulders, and a red hematoma (bruise) on the back of his head. The fall was reported to the nurse who assessed the resident and implemented additional monitoring of the resident's vital signs and neurological status. The next day, the resident was sent to the emergency room after staff noted an increase in confusion and agitation. Hospital records indicated diagnostic imaging confirmed the resident had an acute subdural hematoma (bleeding in the brain) and the resident was hospitalized for five days.

The facility completed an incident report and internal investigation of the fall, as the fall was not normal for the resident. Documentation reviewed during the internal investigation indicated that the resident's service plan was followed and safety checks and toileting services were signed off by a night shift staff member/alleged perpetrator (AP).

While investigating the fall, administration reviewed security camera footage and discovered the resident's safety checks and toileting were not provided, as the AP did not enter the resident's room after 11:05 p.m. The internal investigation included an interview with the AP who said she checked on the resident at midnight, 1 a.m., 2 a.m., 3 a.m., and 4 a.m. and that the resident had his call light within reach. The AP denied not providing the scheduled services and didn't know why camera footage would not show her entering the resident's room during her shift.

Administrative staff interviewed another staff member who worked with the AP the night of the fall. The staff member reported that the AP was at the nurse's station every time they saw her and found it odd that the resident didn't call during the night, as the resident was known to frequently use his call light.

During an interview, administrative staff stated the resident's fall wasn't consistent with previous falls and something didn't seem right. While investigating the root cause of the fall, camera footage was reviewed and compared to documentation of services provided. The camera footage indicated the AP did not enter the resident's room or the hallway the resident resided on, for most of the shift. The AP told administrative staff that there must have been an issue with the camera by the resident's room, so they reviewed camera footage from a different vantage point which further confirmed the AP did not enter the resident's room.

During an interview, the AP stated she performed safety checks as scheduled on her shift except for the 4:00 a.m. check, since she was assisting staff with another resident. The AP was asked why security camera footage did not show her entering the hallway of the resident's room, and the AP stated it was because the facility deleted stuff if they didn't like you and reiterated again that she provided the resident's scheduled services.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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; due to cognitive impairment.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility reported the incident, investigated the resident's fall, and determined the service plan was not followed at the time of the incident. The facility terminated the AP and retrained all staff on the importance of following the plan of care.

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
	30668	A. BUILDING: _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK COURT OF BEMIDJI	1511 DELTON AVENUE NW BEMIDJI, MN 56601

(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 July 3, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306683766C/HL306683501M. No correction orders are issued.	0 000		