State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307303764M
Compliance #: HL307304212C

Date Concluded: October 3, 2024

Name, Address, and County of Licensee Investigated:
Traditions of Montgomery
399 Lexington Ave NW
Montgomery, MN 56069
Le Sueur County

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

Evaluator's Name: Lena Gangestad, 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 alleged perpetrator neglected the resident when the alleged perpetrator did not notify the nurse before assisting the resident back to bed after a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true the alleged perpetrator and another unlicensed caregiver did not contact the on-call nurse prior to moving the resident, there was a lack of evidence to indicate this caused the resident's fracture as neither caregiver reported no pain when the resident was moved nor when they contacted the on-call nurse afterwards.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include altered mental status. The resident's service plan included assistance of one person with all activities of daily living which included hygiene, dressing, and toileting. The service plan also included safety check once at night and as needed.

An incident report indicated the alleged perpetrator heard the resident yell for help and found her on the floor in front of her bed in the early morning. Same document indicated there was no injury identified at that time.

The progress notes indicated the resident could not describe how the fall occurred but said she hit her head. The same document indicated the resident was transferred back to bed and there were no obvious signs of injury or pain at that time. The on-call nurse was notified of the fall shortly after the resident was successfully to bed and did not report any signs or symptoms of pain. However, later the same morning, the resident was hollering in pain and refused to move or go to breakfast. The facility nurse assessed the resident in-person about five hours after the fall and found the resident with severe pain with minimal movement of her left leg, complaining of hip pain, and asked the nurse to not move her. The facility notified the family and sent the resident to the hospital.

During an interview, the nurse, who had been on-call that night, stated the facility practice was for unlicensed caregivers to call the nurse before moving a resident, however in this instance the two caregivers moved her prior to contacting her. When they did call, they said the resident appeared to be without pain. The nurse stated when she came to work in the morning and was informed by the morning staff that the resident was in so much pain she did not want to be touched or moved. The nurse then decided to send her to the hospital for further evaluation. The nurse confirmed there were two staff members in the room, both of whom helped move the resident back to bed. The alleged perpetrator was primarily responsible for the resident's care, and the other unlicensed caregiver assisted the alleged perpetrator in transferring the resident.

During the investigation, despite multiple attempts, the investigator was unable to reach the other unlicensed caregiver who worked on the night of the incident.

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 was unable to be interviewed due to dementia.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: No, attempted but did not reach.

Action taken by facility:
The facility started an internal investigation and re-trained the staff members about the fall protocol to reduce the risk of recurrence.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30730	A. BUILDING: ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MONTGOMERY LLC	**399 LEXINGTON AVENUE NW MONTGOMERY, MN 56069**

(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 September 19, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL307303764M/HL307304212C. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE