Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307456565M
Compliance #: HL307452281C

Date Concluded: August 5, 2023

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes MN 55014
Anoka County

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

Evaluator's Name: Maggie Regnier, 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 facility failed to follow up after a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did develop back pain after she fell, the facility assessed and sought treatment for the resident's pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's medical records, therapy notes, incidents reports, staff schedules and facility policies. Also, the investigator observed staff interactions with residents, other staff, and administrative staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service indicated she required assistance with medications but was independent with mobility including transfers and walking. The medical record indicated she had memory loss.

One day, the resident had complained of mild stomach pain. The facility nurse contacted the provider and was ordered to provide Tylenol for pain as needed. After a few days, the resident reported back pain, so the facility investigated and determined a fall had happened. The resident was able to get herself up from the fall and continued to be mobile. The facility assess the resident but identified no skin discoloration or abrasion. The facility contacted the son and agreed to send the resident to the emergency room to be checked for injury.

During an interview, a member of the management team stated the resident had fallen in the past with no injury noted. During investigative interviews, multiple staff members stated that the resident was very active and never reported the fall to them.

During an interview, the family member stated that the resident had fallen in the past. He also stated the facility did call him when the fall happened initially, and he went to see the resident but decided not to take her to the hospital at that time.

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: Unable to related to cognitive loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility called the family when the fall occurred and involved the family in decision making about transferring to the hospital. The facility is working with staff on documentation expectations for fall events. The facility is learning the importance of documenting internal investigations.

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
	30745	A. BUILDING: _____ B. WING _____	C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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 June 21, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL307452322C; HL307452281C, HL307456565M; HL307451601C, HL307456146M. No correction orders are issued.	0 000		