

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312492142M
Compliance #: HL312493889C

Date Concluded: May 8, 2023

Name, Address, and County of Licensee

Investigated:

Polar Ridge Senior Living
2365 Helen St N
North St Paul MN
Ramsey County

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

Evaluator's Name: Maggie Regnier
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 she got out of bed in the middle of the night and fell in the bathroom.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. While it is true the resident fell overnight in the bathroom, the facility did check on her throughout the night. The facility sent the resident to the emergency room (ER) for treatment appropriately.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of the facility policies, incident reports, residents' medical records, facility records, personnel records, and trainings. Also, the investigator observed staff interactions and medication administration as well as resident interactions.

The resident resided in an assisted living facility in a dementia care unit. The resident's diagnoses included dementia, insomnia, depression, and history of hip fracture. The resident's service plan included assistance with transfers and toileting. The resident's medical record indicated the resident's plan included offering toileting overnight.

One night the resident was found on the floor of her bathroom at about 4:00 a.m. and was sent to the ER for evaluation. The resident's ER records indicated identified previous fractures but did not identify any new fractures, although her hip was dislocated. The resident returned to the facility with medications for pain.

The facility conducted an internal investigation which indicated the unlicensed caregiver checked on the resident multiple times throughout the night shift she fell. The report indicated the unlicensed caregiver offered at 11 p.m. but the resident declined. The unlicensed caregiver checked said she checked on her at around 2 a.m. but the resident usually refuses. The unlicensed caregiver said the resident usually accepted toileting help between 4 and 5 a.m. The same investigation referred to video surveillance which showed the unlicensed giver checking on the resident four times between 11 p.m. and 4 a.m. The same documents indicated the resident's bed was in the low position when the resident got out of bed and fell in the bathroom.

During an interview with a family member, she stated the family was under the impression the resident was toileted every two hours at night and not allowed to refuse. The family also purchased a special bed that could be lowered or raised as needed. The family expected the staff to lower the bed whenever the resident was in bed to lessen the risk of a fall should the resident attempt to get out of bed.

During multiple separate interviews multiple unlicensed caregivers stated the practice at the facility was to not wake residents but did offer toileting if the residents were awake.

During an interview with the nurse, she stated that it was often the practice to not wake residents up to go to the bathroom, but the staff should check on residents every hour or two overnight to see if they are awake, then offer them assistance to the bathroom to be consistent with person-centered care.

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:

The facility did an internal investigation and follow up education with all staff. The facility has implemented motion sensors in rooms that notify staff of movement.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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: 31249	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/15/2023
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NAME OF PROVIDER OR SUPPLIER POLAR RIDGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2365 HELEN STREET NORTH NORTH SAINT PAUL, MN 55109
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL312493889C/#HL312492142M</p> <p>On March 15, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 116 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL312493889C/#HL312492142M, tag identification 2310</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p>	
02310 SS=D	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care</p>	02310		

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

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02310	<p>Continued From page 1 standards.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide care in accordance with accepted healthcare standards for one of one residents (R1) reviewed when the resident suffered repeated falls, and the facility failed to assess, create and implement new care plan and education to address the falls. The facility did not discuss appropriate resident care/interventions with the resident's representative and did not attempt new fall precautions.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings Include:</p> <p>R1's medical record was reviewed. The resident's medical diagnoses included dementia, chronic pain syndrome, insomnia, and muscle weakness with multiple falls.</p> <p>R1's signed service plan, dated April 21, 2022, indicated she received services for medication management, nurse visits to include assessment/monitoring of changes in health status, and heavy assistance with activities of daily living. Records indicated the resident moved into the facility in August 2018.</p>	02310		

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02310	<p>Continued From page 2</p> <p>A review of R1's record indicates the resident had several falls in the months leading up to her discharge. One fall, that caused a fractured hip, was sustained while visiting family, away from the facility on April 2022. The resident returned to the facility for care and services after surgery and rehab.</p> <p>The Resident Incident Report dated July 8, 2022, indicated the resident was found on the floor in her bathroom at approximately 4 a.m. suffered serious injury. Emergency medical services transported the resident to the emergency room.</p> <p>The resident's hospital notes dated July 8, 2022, indicated the resident suffered a dislocated hip, which physicians replaced and sent the resident back to the facility</p> <p>The facility could not provide any documentation for fall interventions put into place after the resident's July 8 2022 fall. The care plan was not updated, the service plan was not updated</p> <p>The facility did retrain staff on customer service rounds after the resident fell, it failed to train staff on the specific bed R1 was using to prevent falls.</p> <p>During an Interview on March 28, 2023 at 3:43 p.m., the director of nursing (DON)-B stated she did not think it was necessary to train the staff on the bed use.</p> <p>Facility provided document titled Fall Risk and Prevention effective date November 2014 and revision dates February 2019, February 2021, June 2022 and August 2022 states that once established all interventions need to be listed on the care plan.</p>	02310		

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02310	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty one (21) days	02310		