DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324194101M
Compliance #: HL324194742C

Date Concluded: September 10, 2024

Name, Address, and County of Licensee Investigated:
Gable Pines at Vadnais Heights
1260 County Road E
Vadnais Heights, MN 55110
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 resident was found on the floor with a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had morning medication administration as a scheduled service. The resident refused morning medications, and although the facility failed to follow-up with the refusal of medications, the facility did not fail to provide the resident with care planned services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and other resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included mild cognitive impairment and muscle weakness. The resident's service plan included assistance with medications once a day in the morning that included two medications, an antidepressant pill, and an iron pill. The resident was independent with personal hygiene, walking, transferring, could dress and undress herself with reminders, and required verbal reminders for toileting assistance.

An incident report indicated one afternoon a facility staff member and the resident's family member found the resident on the floor in the bathroom. Emergency medical services was called, and the resident was transported to a hospital for an evaluation.

The hospital record indicated the resident sustained a right hip fracture. The hospital record indicated the resident did not recall what happened and had an unwitnessed fall.

The facility investigation indicated the resident refused her morning medications. The facility investigation indicated a kitchen staff recalled seeing the resident in the dining room for breakfast and lunch. The facility investigation indicated the resident may have laid down for a nap after lunch. The resident soiled the bed, got up to shower and fell attempting to get into the shower.

During an interview, kitchen staff member stated she recalled seeing the resident in the dining room for breakfast the day the resident fell.

During an interview, a facility nurse stated the resident was independent with cares, got herself dressed, and would walk independently while using a walker. The resident needed assistance with medication administration, and the resident normally took her medications in the morning. The facility nurse stated the day the resident fell, the resident refused to take her medications and the resident was found on the floor in the bathroom that afternoon. The facility nurse stated resident did not have a history of falling at the facility.

During an interview, facility leadership stated the resident celebrated a birthday party the weekend prior to the incident. The resident appeared tired from the celebration throughout the week. Leadership stated during the facility investigation it was determined although the unlicensed staff member failed to notify the facility nurse that the resident refused her morning medications, the resident was found on the floor in the afternoon and was in the dining room for breakfast and lunch and fell after lunch.

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

Action taken by facility:
When the resident was found on the floor of the bathroom, emergency medical services was called, and the resident was sent to the hospital.

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
	32419	A. BUILDING: _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABLE PINES AT VADNAIS HEIGHTS	**1260 EAST COUNTY ROAD EAST VADNAIS HEIGHTS, MN 55110**

(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 August 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL324194101M/#HL324194742C. No correction orders are issued.	0 000		