Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL330821260M
Compliance #: HL330828747C

Date Concluded: June 20, 2024

Name, Address, and County of Licensee Investigated:
Cardigan Ridge Senior Living
3300 Rice Street
Little Canada, MN 55126
Ramsey County

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

Evaluator's Name: Brooke Anderson, 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 resident #1 and resident #2 when the facility failed to supervise the residents, resulting in a physical altercation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although Resident #1 and Resident #2 got into a physical altercation and Resident #2 was sent to the hospital, the resident's care plans were being followed at the time of the incident and neither resident had a history of previous physical altercations with other residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the residents' records, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included vascular dementia. Resident #1's service plan included assistance with medication administration and behavioral management. Resident #1's assessment indicated the resident had poor decision making, poor safety awareness, required frequent redirection, and did not pose a risk to other residents.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnosis included dementia. Resident #2's service plan included assistance with dressing, grooming and medication management. Resident #2's assessment indicated the resident did not pose a risk to other residents.

Facility documentation indicated Resident #1 and Resident #2 were in the common area watching tv together and when a staff member entered the area, she saw blood on Resident #2's face, hand, and left arm and noticed that the residents were sitting in separate chairs. Staff contacted the facility nurse, separated the residents, and contacted 911. Resident #2 was sent to the emergency room (ER) for evaluation.

Medical records indicated Resident #2 was treated for a skin tear on his left forearm, left eye abrasions (scrapes or cuts) and broken teeth. Resident #2 was discharged back to the facility. Resident #1 had no injuries.

During an interview, the staff member working at the time of the incident stated both residents were watching tv together when she left the common area to assist another resident. Upon her return she noted there were glasses, teeth, hearing aids, and blood on the floor. The two residents were sitting in chairs in front of the tv. She contacted the facility nurse who came to the unit to help redirect the residents away from each other and 911 was called. The staff member stated that the residents had no history of physical altercations, but had previous verbal behaviors towards staff and each other, however many interventions had been put in place.

During an interview, the facility nurse stated facility staff were re-educated on interventions for resident-to-resident altercations. After the incident, Resident #2 moved to another memory care unit and additional education on dementia and how to redirect and distract resident behaviors, was provided to staff to prevent further reoccurrence.

During investigative interviews Resident #1 and Resident #2's family members stated the facility handled the situation swiftly and the families had no concerns with the care provide at the facility.

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, Resident #1 is deceased. Resident #2 was unable to be interviewed due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented interventions prior to the incident and immediately responded to the incident. Following the incident, staff were re-educated on dementia and resident behaviors.

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
	33082	A. BUILDING: _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDIGAN RIDGE SENIOR LIVING	3300 RICE STREET SHOREVIEW, MN 55126

(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 May 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL330828747C/#HL330821260M. No correction orders are issued.	0 000		