Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352303044M
Compliance #: HL352304967C

Date Concluded: May 19, 2023

Name, Address, and County of Licensee Investigated:
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, Minnesota 55443
Hennepin County

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

Evaluator's Name: Nicole Myslicki, 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 (AP) neglected a resident when the AP witnessed the resident fall and hit her head. Additionally, the facility neglected the resident when staff failed to provide services within her plan of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident leaned forward while toileting and hit her head on a grab bar. The resident did not fall. Staff responded and assisted the resident. Staff followed the resident's service plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of grievances, incidents, policies including vulnerable adult, assessments, toileting, transfers, and pendants. The investigation also included review of the resident's medical record. Also, the investigator observed lunch service, toileting, and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included cancer. The resident's service plan included assistance with toileting three times daily, meal delivery daily, and safety checks daily. The resident's assessment indicated the resident was on hospice and had at least three falls within the three months prior. The resident's service delivery record indicated the resident received meal delivery twice daily and toileting three to eight times every day of the month during which the concerns occurred.

An incident report indicated the resident became lightheaded in the bathroom while on the toilet and fell forward, hitting her head on the grab bar. The resident did not fall to the floor. The resident's vitals signs were taken and were within normal limits. The report indicated the unlicensed personnel (ULP) assisted the resident with toileting and helped her back into her wheelchair. The resident sustained a small bruise to the upper right part of the forehead. The ULP notified the lead ULP of the incident.

During an interview, a nurse stated the resident got lightheaded on the toilet, went forward, and hit her head on the grab bar. The nurse stated she did not fall to the ground.

During an interview, the ULP stated staff responded to residents any time they pushed their pendant. Regarding meals, staff took meals directly from the kitchen to the resident's room. If in a wheelchair, the staff would bring the resident to the table to eat. Regarding the resident, the ULP stated she frequently used her call light pendant to use the bathroom throughout the shift, and the staff would answer it each time.

During an interview, the resident's family member stated she should have received a call since the resident hit her head. The family member stated the resident's meals would arrive late if they were delivered at all. One time, the resident had to wait over an hour to use the bathroom. Additionally, the resident had been told on multiple occasions she could not use her call pendant. The family member also stated she thought staff needed better training.

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 vulnerable adult is deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed an incident report. The nurse investigated concerns of lengthy call light times.

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
	35230	A. BUILDING: _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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 March 15, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL352304967C/#HL352303044M and HL352308595C/#HL352305003M. No correction orders are issued.	0 000		