Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352305003M
Compliance #: HL352308595C

Date Concluded: April 25, 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: Inconclusive

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 with the provider after notifying them of symptoms the resident displayed. Subsequently, the resident admitted to the hospital with blood clots in the right lower leg and lungs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident developed blood clots in the leg, the subsequent hospital admission and blood clots in the lungs could not be directly caused by the lack of action from nursing based on the available evidence. Unlicensed staff members were unable to recall events or details during interviews. Additionally, the provider declined to interview due to inability to recall events.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the physician. The investigation included review of the resident's medical records and hospital records, staff schedules,

grievances and incident reports, and internal investigation. Also, the investigator observed staff interactions with residents, transferring, and toileting.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and high cholesterol. The resident's service plan included assistance with medication administration, transfers, and oxygen saturation checks. The resident's assessment indicated the resident required the use of a sit-to-stand lift (a lift which lifts the person from a sitting position to a standing position).

One day during normal business hours, a facility nurse messaged the resident's provider on an electronic communication portal, indicating the resident had a swollen right ankle and requested advice.

Less than one hour later, one of the resident's providers sent a message asking if the area was red, warm or painful to touch, as well as if the skin was tight, shiny, or if there was any blister formation. The provider also asked for confirmation regarding whether the swelling was on one ankle or both. The facility staff did not respond to this message.

Two days later, the resident's family member messaged the portal indicating the resident's leg was still swollen, did not hurt, did not feel warm or look red, and looked shiny and tight.

Two hours later, one of the providers messaged back, ordering an ultrasound as soon as possible (ASAP) to rule out a blood clot.

One day later, the ordering provider messaged again, asking nursing to confirm the ultrasound would be completed that day.

Eight hours later, a nurse responded the order was placed, and the company would arrive by the end of the day to complete the ultrasound.

The next morning, a nurse sent a message indicating the results were back, and extensive blood clots were seen in the right leg.

Less than one hour later, the ordering provider requested a full set of vitals, including oxygen saturation. The provider also ordered a blood thinner.

Approximately four hours later, another nurse messaged the portal, indicating the resident had been sent to the hospital nearly five hours earlier with a low oxygen saturation of 87 percent and suspecting a pulmonary embolism.

Hospital records indicated imaging of the resident's chest identified multiple blood clots in both lungs. The resident admitted to the hospital and started on Heparin (a blood thinner used to

stop the blood from clotting) intravenously. Four days later, the resident discharged back to the facility with orders for a blood thinner to be taken by mouth for 21 days.

During an interview, the resident stated she did not have long term effects from the blood clots and thought she reached back to baseline regarding her health.

During an interview, the resident's family member stated she believed if her sister had not logged onto the electronic portal and seen the facility staff did not respond to the provider's questions, the resident could have died from the blood clots in her lungs.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an investigation and instructed nursing to check the electronic portal at least daily.

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		