Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378163802M
Compliance #: HL378164254C

Date Concluded: August 19, 2024

Name, Address, and County of Licensee Investigated:
Lindstrom Senior Living
30455 Lehigh Ave
Lindstrom, MN 55045
Chisago 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 facility staff failed to follow the resident's plan of care. The resident fell and hit her head resulting in injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff followed the resident's care plan at the time of the resident's fall. The resident stood in the dining room without staff awareness and fell on the floor sustaining a cut to the resident's head.

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and osteoporosis (weak and brittle bones). The resident's service plan included physical assist from one staff for transfers, dressing and grooming. The resident was a high fall risk and required a sensor pad in bed (a weight-sensitive sensor pad that is connected to a monitor unit and activates an alarm if the resident left the bed). The resident was alert, forgetful, impulsive, and made poor decisions.

The resident's incident report indicated one day the resident fell in the dining room. The report indicated when a staff member was distracted assisting a different resident, the resident stood and fell without requesting staff assistance. The staff member heard a loud noise and saw the resident on the floor. The resident sustained a cut to her head and was transported to the hospital.

The resident's hospital records indicated the resident sustained a cut to her head. The resident's cut was glued, and the resident returned to the facility.

During an interview, an unlicensed staff member stated she was helping another resident when she heard a "thump" noise. The unlicensed staff stated the resident got up from a dining room chair without the unlicensed staff member knowing and fell. The unlicensed staff member stated she looked over and saw the resident on the floor, bleeding from her head. The unlicensed staff member called a facility nurse and emergency services. The unlicensed staff member stated at the time of the incident, the resident only used the sensor pad in bed.

During an interview, nursing leadership stated the resident had a couple falls that involved the resident transferring without calling for help. The nurse leadership stated facility staff completed a fall risk assessment after each fall and new interventions were developed and put in place. After the fall in the dining room, the resident's sensor pad was to be used in bed, in the chair, the recliner, and wheelchair. Nursing leadership stated other fall interventions for the resident included arranging the resident's room placing frequently used items within the resident's reach, increased safety checks, and physical assist of one staff when the resident is walking.

During an interview, a family member stated the resident would just stand up and start walking without calling for help. The family member stated after the resident's fall, the facility used an alarm at all times. When the resident stood up, the alarm would make a noise.

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. Due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
After the resident fell, the resident was sent to the hospital. The facility then added an intervention to prevent falls that included a sensor pad to be placed in the resident’s wheelchair, chair, recliner, and bed.

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
	37816	A. BUILDING: _____ B. WING _____	C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

(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 ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL378163802M/#HL378164254C #HL378163681M/#HL378164102C On July 23, 2024, 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 88 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL378163681M/#HL378164102C, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced	02360		

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02360	Continued From page 1 by: The facility failed to ensure one of two residents reviewed (R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		