Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL389839408M
Compliance #: HL389837206C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Personal Care Senior Living
3850 Jefferson Street Northeast
Columbia Heights, Minnesota 55421
Anoka 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 facility neglected the resident when the resident fell, and the facility did not send the resident to the hospital until almost one week later. The resident went to the hospital and was diagnosed with a head injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and did not go to the emergency department (ED) until one week later, the facility monitored him after the fall and provided pain medication as needed. Hospital records showed there was not an injury to correlate to the blood found with imaging in the brain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death record, hospital records, facility internal investigation,

facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed assistance with transfers.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with medication administration, safety checks, and transfers. The resident's assessment indicated he had a history of falls.

An incident report indicated the resident had been alone in his room when he heard someone say they were going somewhere. The resident tried to get out of his wheelchair to go with. The resident skinned his right knee and elbow.

A progress report indicated an unlicensed personnel (ULP) notified a nurse the resident fell. The nurse went to help the ULP and assessed the resident who denied any pain. The nurse notified family and directed ULP to notify her if there were any changes in his condition.

One day later, a progress note indicated the nurse provided ice and administered acetaminophen (a pain-relieving medication) as needed for hip pain. These interventions were effective.

The next day, a progress note indicated the nurse spoke with the resident's family member to discuss the fall and hip pain while at the facility.

The following day, a progress note indicated the resident did not complain of pain to the nurse, and morning staff did not report he complained of pain.

Two days later, a progress note indicated the resident wanted to go to the ED due to pain in his hip.

The resident's medication administration record (MAR) indicated the resident received acetaminophen twice between the fall and hospitalization.

The resident's hospital records indicated he reported worsening hip pain and a headache upon arrival to the ED. The resident reported sliding down from his bed and landing on the floor. He denied loss of consciousness, dizziness, or lightheadedness. A hospital provider assessed the resident and found him to be neurologically intact, as well as alert and oriented. Imaging found the resident had a hematoma (a localized collection of blood in the tissue of the body, outside of the blood vessels). Imaging did not find any evidence of injury or bleeding in the brain. The hospital diagnosed the resident with a chronic, post-traumatic headache. The resident admitted to the hospital for five days before returning to the facility.

During an interview, a nurse stated a staff member reported the resident fell, so she checked on him. His vitals were okay, and he said he fell on his side. The resident had been aware of his surroundings and what happened, and he could report whether he had pain or needed

something. This nurse also checked on him again the next day. During the time after his fall and before he went to the hospital, the resident would still get up and move around at his baseline.

During an interview, the ULP stated she contacted an on-call nurse after the resident began complaining of pain during her shift. The nurse approved for the resident to be sent into the ED.

During an interview, a family member stated the resident stated he had been fine at first after the fall. She saw him each day and when he complained of pain, they brought him into the hospital. The hospital did not find any other injury besides the large, painful bruise, and he returned to his baseline. The family member stated she had been very pleased with the facility and how they handled the situation.

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

Action taken by facility:
The facility monitored the resident, provided ice and over the counter pain medication, and stayed in contact with the family. The facility also sent the resident into the hospital when he requested.

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
	38983	A. BUILDING: _____ B. WING _____	C 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE SENIOR LIVING	3850 JEFFERSON STREET NE FRIDLEY, MN 55432

(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 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL389839652C/#HL389831941M and #HL389837206C/HL389839408M. No correction orders are issued.	0 000		