Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200966323M
Compliance #: HL200961872C

Date Concluded: November 22, 2023

Name, Address, and County of Licensee Investigated:
Northfield Parkview INC
910 Cannon Valley Drive
Northfield, MN 55057
Rice

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of the 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 a resident when a staff member left them alone in the bathroom, resulting in the resident's fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell, the error was an isolated incident. The resident suffered a hematoma on their forehead, received treatment in the Emergency Room (ER), and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living building. The resident's diagnoses include dementia and pleural effusion (a buildup of fluids in the lungs and chest). The resident's service plan included assistance of one person with hygiene, dressing, toileting, and medications.

One night a staff member heard the resident getting up in his room, so he entered the room and assisted the resident to the bathroom. After helping the resident sit on the toilet, he left to respond to another call light. While the staff member was gone, the resident fell and hit his head.

The resident progress notes indicated staff member heard the resident fall and returned immediately. The same document indicated the staff member observed labored breathing and the resident was sent to the emergency department. The resident returned from the emergency room the next day with an antibiotic ordered to treat a urinary tract infection.

The day before this incident the resident's progress notes indicated the resident was seen by his medical provider after a recent hospitalization. The same progress noted indicated the resident had audible wheezing but described his lungs sounds as clear and with no deep wheezing. The same document indicated the plan for was for a follow-up appointment about five days later with the medical provider.

During an interview, a nurse stated she was notified and spoke to the staff member on duty that night. As there was only one staff member working, he left the resident alone in the bathroom to assist another resident. The nurse clarified only one staff member was assigned during the night shift. Following the incident, a new intervention was added to the care plan a day later, ensuring staff stayed with the resident at all times. Additionally, a bed alarm was implemented. The nurse said a focus assessment was conducted after the resident's discharge from both hospital stays.

During an interview, the staff member stated he worked overnight and helped the resident use the bathroom that night. After assisting the resident to sit down, he noticed another call light was on, so he left the resident alone momentarily. Upon hearing a noise, he quickly returned to find the resident had fallen. He called for assistance, and the resident was subsequently taken to the hospital. The staff member noted up until that day, they were not required to stay with the resident in the bathroom. However, after the incident, new protocols were implemented, and staff were instructed to stay with the resident within arm's reach at all times.

During an interview, the family member stated the resident had been discharged from the hospital recently due to fluid overload. A day after returning, he fell in the bathroom and was taken to the ER during the night. Although he had a hematoma on his head, there was no major injury, so he was discharged the next day. The family member also noted the facility informed her promptly about the incidents. The facility took steps to address the situation, implementing

bed and chair alarms, and relocating his room closer to the nurse's station for better monitoring by the staff.

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

Action taken by facility:
After the resident's discharge, the facility conducted a focused assessment. A new intervention was implemented, requiring staff to remain within arm's reach of the resident at all times. Additionally, chair and bed alarms were installed, and the resident's room was relocated closer to the nurse's station.

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
	20096	A. BUILDING: _____ B. WING _____	C 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD PARKVIEW INC	910 CANNON VALLEY DRIVE NORTHFIELD, MN 55057

(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 October 24, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL200966323M/HL200961872C. No correction orders are issued.	0 000		