Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202579282M
Compliance #: HL202577863C

Date Concluded: April 29, 2025

Name, Address, and County of Licensee Investigated:
North Ridge Health and Rehab
5500 Boone Ave N
New Hope, MN 55428
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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, who was found lying in bed, from fractures and bruising. He was sent to the hospital where he was diagnosed with fracture and eventually passed away.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The investigation found there was insufficient evidence to determine if neglect occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident lived in a secured memory care unit within an assisted living facility. He had been diagnosed with dementia and required assistance with all activities of daily living, including hygiene, dressing, toileting, medication administration, meals, and incontinence cares.

According to the resident's assessment, he was noted to be verbally aggressive, often displaying angry outbursts including cursing and swearing.

On December 27th, unlicensed caregivers, while trying to provide incontinence cares, found a purple bruise on the resident's right shoulder extending down to his ribs. This was reported to the physician assistant during his visit to the facility. After assessing the resident, the physician assistant ordered the resident transferred to the emergency room for further evaluation.

Additionally, a concern arose that the facility had not provided cares sufficiently from a previous fall about one week earlier and the bruising and injuries had gone unidentified. There were also concerns about his cares regarding incontinence cares and lymphedema management.

In October, the resident's physician assistant notes indicated the resident had a history of refusing care, particularly related to the management of lymphedema [severe swelling]. He frequently removed his wraps, which led to the discontinuation of occupational therapy services for edema management.

During one of these visits in October, the resident became extremely agitated, refused to sit still, and attempted to strike the physician assistant. The physician assistant notes also indicated the resident's care was difficult to manage due to his violent behavior and non-compliance with care routines.

Additionally, according to the same physician notes, the resident was ambulating independently without the use of any assistive device.

In November, the physician assistant notes described his aggressive behavior occurred at least twice a week, without any specific pattern relating to the time of day. Staff members reported these behaviors were most frequent during care routines. His personal hygiene was poor, largely because he frequently refused care from caregivers. The resident was incontinent of both bowel and bladder, and due to his combative nature, care often required three staff members. Over time, his aggressive behavior had slowly worsened.

The notes also referenced input from a family friend, who observed that while the resident used to have a wet brief during visits, it had recently been dry, suggesting that he might have started allowing staff to change his brief. However, despite this, there was significant skin breakdown in his bottom and groin areas due to the ongoing refusal of care. Ointment was ordered to treat this breakdown.

On December 12th, the physician assistant notes indicated the resident was seen again for Alzheimer's disease, ongoing combativeness, and refusal of care.

On December 27th, the physician assistant notes indicated the resident was seen at bedside accompanied by a nurse and a family member, due to concerns about poor intake and right

shoulder bruising and swelling. The physician assistant observed a large amount of fading ecchymosis on the resident's right shoulder, with edema extending down toward the elbow and up toward the neck. The resident did not voluntarily move his right upper extremity and displayed nonverbal signs of pain during passive range of motion The physician assistant transferred the resident to the emergency room.

The same document indicated the resident appeared thin and dehydrated, with minimal edema in his legs, which was significantly different from his baseline of having massive bilateral lower extremity swelling. The physician assistant reviewed the most recent falls, noting a fall on December 17th where the resident was found on his buttocks in the dining room without injury, and another fall on December 19th, also reported without injury. The physician assistant questioned whether the shoulder injury might have been new since December 23rd, as lab work drawn that day had shown no major concerns aside from low protein, low albumin, and mild anemia. A family member said that a close family friend, who typically cared for the resident closely, had been ill and had not visited recently to report concerns.

The resident's medication administration record indicated that the resident was considered a fall risk and required staff to check on him every two hours. The records indicated that these checks were performed consistently until the time he was sent to the hospital.

The progress notes further indicated he had fallen on December 15th, 17th, and 19th. Each time, the nurse assessed him, found no apparent injuries plus the facility notified the family and the resident's physician assistant. Additionally, on December 24th, staff observed the resident appeared pale and weak, so the nurse assessed him and attempted to feed him lunch, which he refused. The family was notified about his refusal to eat.

The resident remained at the hospital for approximately 10 days, entered hospice, and passed away the next day.

During an interview, family member #1 stated that the facility called her on December 17th to notify her about the resident's fall, telling her that he did not sustain any injuries. She also received a voicemail from the facility on December 24th informing her that the resident had started refusing food.

During an interview, family member #2 stated he visited the resident on December 27th. He saw the resident lying flat in bed wearing only an adult diaper, while staff were attempting to put a shirt on him. The staff noticed bruising on the resident's chest and right arm and reported this to the nurse. The nurse and physician assistant then came to assess the resident.

During an interview, the nurse stated the resident did not use any assistive devices and walked independently, though he was unsteady and often moved from chair to chair. She said the resident resisted care, did not want to be touched, and frequently refused to be changed when incontinent or showered. Caregivers would attempt to re-approach him several times until he

allowed them to provide care. She stated she assessed him after his fall on December 17th and found no injuries at that time. She was unsure about the details of the incident on December 19th. The nurse noted that the first time she saw the bruise on the resident's chest was on December 27th and she did not know how or when it occurred, as she had not seen any bruising before that day.

During an interview, an unlicensed caregiver stated she had worked at the facility for six years and helped care for the resident because he was often aggressive toward staff and refused care. She said sometimes he would try to hit or harm staff members. When this happened, staff would try to re-approach him or call the nurse for assistance. She said that a family friend visited regularly and was the only person the resident consistently allowed to provide care.

In conclusion, the Minnesota Department of Health determined neglect was not.

"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: The facility followed the plan of care, conducted an assessment, and notified the physician in a timely manner. The fracture and bruising on the resident's chest were of unknown origin; however, the facility promptly informed the physician.

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
	20257	A. BUILDING: _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT NORTH RIDGE	5500 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 April 2nd, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL202579282M/HL202577863C. No correction orders are issued.	0 000		