Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306253902M
Compliance #: HL306257529C

Date Concluded: August 11, 2025

Name, Address, and County of Licensee Investigated:
Northern Oaks Place
1005 Paul Parkway NE
Blaine, MN 55434
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 resident was neglected when the resident fell and was improperly transferred off of the floor by a facility staff member/alleged perpetrator (AP), resulting in the resident's right shoulder being dislocated.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although staff did not follow facility protocol when transferring the resident off of the floor following a fall, it was unable to be determined if the resident's right shoulder dislocation was a result of the transfer.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospital staff. The investigation included review of the resident record(s), hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the facility environment and staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and osteoporosis. The resident's service plan included daily staff assistance with dressing, grooming, transfers, toileting, wheelchair mobility, ambulation assistance, medication management, behavior monitoring and five safety checks per day.

The resident's assessment indicated the resident was oriented to person, place, and time with occasional evening disorientation, anxiety, and agitation. The assessment also indicated the resident had a history of falls. The resident's assessment indicated the resident was unable to lift herself independently from a knee-height chair but could ambulate short distances with staff assistance and a transfer belt. The resident's physical therapy notes recommended staff to use a gait belt when the resident was transferred.

Facility documentation indicated that one evening the resident sat too close to the edge of the bed and slid down to the floor landing on her buttocks. The AP transferred the resident back to bed by having the resident hold on to her walker, putting an arm under one of the resident's arms and lifted the resident off the floor holding on to the back of the resident's pants. The AP reported that the resident did not have any observed injury and did not complain of pain.

The resident's medical records indicated staff communicated with the resident and checked on the resident throughout the remainder of that night and the resident had no complaints of pain until the following morning when staff attempted to remove the resident's sweater and the resident complained of pain in her arm. The staff member immediately reported the resident's complaints of pain to nursing staff.

The resident's medical records indicated dayshift staff administered the resident's prescribed pain medication and later was informed by the resident that the pain medication was ineffective. Dayshift staff reported the resident's pain to the family and the facility administrative nurse.

The resident's medical records indicated the resident's family decided to transport the resident to the hospital later that day due to the resident's continued complaints of right arm pain.

The resident's hospital records indicated an x-ray of the resident's right shoulder revealed a dislocation. The medical records indicated hospital medical staff attempted to reduce the

dislocation but were unsuccessful and the resident required surgical intervention to repair the dislocated shoulder.

During an interview, the AP stated she assisted the resident to get ready for bed and while the resident was in bed, the AP turned around to clean next to the resident's bed. When the AP turned back around, the resident attempted to get out of bed and was sliding down the side of the bed. The AP stated she did not have time to grab the call light on the wall or a gait belt. Instead, she blocked the resident from falling on the floor, then slid the resident between herself and the bed and assisted the resident to a seated position on the floor. The AP then grabbed the resident's nearby walker, placed it in front of the resident, placed the resident's two hands on the walker, and assisted the resident to stand by placing her arms under the resident's arms. The AP stated she waited a few seconds for the resident to stabilize then transferred the resident back onto the bed. The AP stated there was no observations of injury or any abnormal movements from the resident's arm joints. The AP stated she did not want to leave the resident on the floor which is why she did not call for assistance with the transfer. The AP stated she forgot about the incident which was why she did not report it or complete a facility incident report. The AP stated she recalled checking on the resident's later in the shift, and the resident did not complain of pain or discomfort.

During an interview, the facility administrative nurse stated the resident was in physical therapy (PT) at the time of the fall and the resident had a history of falls. The facility administrative staff stated the resident was able to vocalize pain and recalled the AP was confident the resident had no complaints of pain after the improper transfer. The facility, administrative nurse stated he interviewed night staff who worked the night following the resident's improper transfer and stated staff informed safety checks were completed throughout the night and there were no complaints of pain until the report made to morning shift staff.

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: No, per family and cognitive deficits
Family/Responsible Party interviewed: No, family declined to interview
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Staff were re-educated on falls, incident reports and proper procedure for resident transfer with a gait belt.

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
	30625	A. BUILDING: _____ B. WING _____	C 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN OAK PLACE	1005 PAUL PARKWAY NE BLAINE, MN 55434

(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 July 17, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306257529C/#HL306253902M. No correction orders are issued.	0 000		