Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338047762M
Compliance #: HL338043307C

Date Concluded: February 5, 2025

Name, Address, and County of Licensee Investigated:
Orchard Path
5400 157th Street West
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, facility responsibility

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 had ongoing, multiple falls and staff did not implement interventions to prevent further falls. The resident sustained a broken hip, broken shoulder, and a laceration to her head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had approximately 36 falls in six months, several of which resulted in skin tears and bone fractures. The facility failed to investigate the cause, reassess the resident, and implement new, effective fall interventions after each fall.

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's records, the resident's pendant log, hospital records, facility incident

reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and resident interactions with staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's services included assistance with activities of daily living, transfers and toileting, meals, medication management, laundry, and housekeeping. The resident's assessment indicated the resident required full cares due to physical and cognitive impairment.

The resident's medical record indicated the resident fell 32-36 times over a period of six months. In the timeframe investigated, the resident's progress notes indicated after the first documented fall a portable x-ray was negative for injuries. However, the resident continued to complain of increasing pain. A physical therapy/occupational therapy (PT/OT) consult was ordered. Nearly three weeks later, the resident fell again. A portable x-ray indicated. an "old avulsion on the right great trochanter." Family took the resident to the hospital where she was diagnosed with a stable greater trochanteric fracture (right hip). There were no updates noted in the resident's care plan or abuse prevention plan. The falls follow up form completed by a nurse indicated the long-term intervention was advising family not to leave the resident alone in her room.

The resident's hospital records indicated the resident was diagnosed with a closed nondisplaced fracture of greater trochanter of right femur, with a chief complaint of hip pain. The resident was considered stable for outpatient orthopedic follow-up and non-surgical management.

The resident's progress notes indicated after she fell again staff found the resident on the floor near her bathroom. She had skin tears to her arm and knee (unspecified as to left or right) and was soiled with fecal matter. The resident's record lacked documentation of an incident report or assessment by a nurse. No new fall interventions were implemented, nor was the care plan or abuse prevention plan updated.

The resident's progress notes indicated another fall resulted in an acute to subacute communicated fracture of the acromion (shoulder). The notes did not specify if it was the right or left shoulder that the resident fractured. A nurse completed a fall follow up five days after the fall. The long-term intervention was documented as the facility received the resident's medications from hospice to reduce anxiety/agitation. Neither the care plan nor abuse prevention plan were updated.

Review of a previously recorded video clip from the resident's apartment the resident was observed emerging from the lower left of the screen and walked slowly toward her wheelchair. The resident grasped the wheelchair and attempted to sit in it, but the wheelchair brakes were not locked. The wheelchair rolled backward, and the resident fell to the floor, landing on her left hip. The resident lay on the floor, on her left side, moaning. The resident yelled for help numerous times, as she was unable to lift herself off the floor. The resident rolled to her right side, lying in a fetal position, and continued to call for help. The resident had been on the floor

for approximately three minutes when the video ended. There was no associated progress note, nursing assessment, fall follow-up form, or update to the resident's care plan or abuse prevention plan associated with this fall. A month prior to this fall, however, progress notes indicated staff were to keep the resident's wheelchair by her bed and locked.

The resident's fall risk summary indicated the resident received a PT/OT referral after her initial fall. The resident's medication regimen was updated to promote sleep and lessen anxiety. The resident's most recent 90-day assessment indicated a history of 10 or more falls in the previous 90 days. The fall risk summary did not indicate any new interventions from the previous assessment to prevent further falls.

The facility's fall policy indicated after each fall a nurse would assess all the factors contributing to the fall event and which interventions were in place. At that time, the nurse would recommend interventions and changes to the plan of care to prevent a repeated fall.

Between progress notes, fall follow-up forms, and a video clip, it was documented the resident fell 36 times in six months. Thirty-five falls were documented in the resident's progress notes, but only 20 of the falls were documented on fall follow-up forms completed by a nurse. One fall, which was recorded on video, was not documented anywhere.

When interviewed, a nurse said the resident originally lived in assisted living with her spouse. The resident's cares increased to the point where her husband was overwhelmed with caring for her, so she moved to memory care. The resident became anxious in memory care, being separated from her husband. She would frequently fall when she got up to look for her husband. The resident was placed on hospice, but the falls continued to increase, especially at night after her husband would leave. The nurse said he did not see the video clip of the resident's fall when she attempted to sit in her unlocked wheelchair. The nurse said there was no specific training provided to lock wheelchairs outside of active transfers, but staff were told to keep the wheelchair locked by her bed. A note was placed on the resident's door, but staff feedback was that the note was too small. A poster was hung up on the door, but there was still no formal training regarding keeping wheelchair brakes locked to prevent falls.

When interviewed, a family member expressed concerns regarding a pattern of call lights going unanswered for extended periods of time, alleged retaliation, medication errors, and frequent falls. After one fall, the family member brought the resident's shoulder pain to the attention of the staff, but the pain was downplayed as the resident pulling herself down the hallway in her wheelchair using the rail, making her shoulder sore. Another family member saw the resident's shoulder as she was dressing for the day and described it a looking "awful" and "black and blue." The family requested an x-ray of the shoulder, which ended up revealing a shoulder fracture. The family member did not believe the resident's care was improving and subsequently moved her to a different facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility held case conferences with family members concerned about the resident’s care.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Apple Valley City Attorney
Apple Valley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33804	A. BUILDING: _____ B. WING _____	C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PATH	5400 157TH STREET WEST APPLE VALLEY, MN 55124

(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 ******ATTENTION****** 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: #HL338049483C/#HL338046342M and #HL338043307C/#HL338047762M On January 7, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 71 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL338049483C/#HL338046342M, and #HL338043307C/#HL338047762M tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 by: The facility failed to ensure two of two residents reviewed (R1 & R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		