Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347162602M
Compliance #: HL347161819C

Date Concluded: July 29, 2024

Name, Address, and County of Licensee Investigated:
Orchards of Minnetonka
10955 Wayzata Boulevard
Minnetonka, MN 55305
Hennepin County

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

Evaluator's Name: Danyell Eccleston, RN, 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 facility neglected the resident when the facility failed to ensure staff used appropriate precautions when transferring and repositioning the resident. The resident sustained a fractured femur (upper leg bone).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Staff found the resident with unexplained bruising and swelling to her right leg and an x-ray confirmed a break to her femur. Medical reports from the resident's hospitalization indicated a traumatic force might have caused the break, however the resident's bones were "considerably demineralized" (the loss of minerals that make up bone structure). Staff members from shifts prior to or during the time of discovery stated they did not know how or when the injury occurred. It could not be determined how the residents fracture 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 medical records, facility internal investigation, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed staff members providing care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Lewy Body dementia, osteoarthritis, and general weakness. The resident's service plan included assistance with bed mobility and repositioning, Hoyer (mechanical) lift for transfers, dressing and changing. The resident's assessment indicated the resident had severe cognitive decline and required physical assistance of two staff members when assisting the resident in bed and transferring the resident with a Hoyer lift.

Progress notes five days before the time in question indicated the resident's skin was intact and the resident denied pain while sitting in a chair.

Progress notes from the morning in question indicated staff noted severe swelling and red, purple, and blue bruising to the resident's right upper leg measuring 10cm wide and 12cm long, and the resident's lower calf measuring 8cm wide and 14cm long. The resident was unable to move her leg and screamed in pain when the injuries were touched. Staff administered pain medication and applied cold cloths to the area. No other injuries to the resident were noted.

An incident report from the time in question indicated staff found bruising to the resident's right leg when assisting the resident with morning cares. The resident could not state how the injury occurred. An x-ray was conducted and indicated the resident had a fracture to her right femur. The resident went to the hospital for further care and pain management.

Hospital records indicated the residents broken femur bone poked through the resident's leg tissue causing a hole in the resident's leg that required surgical intervention. Physician notes indicated the resident's femur bone was "considerably demineralized" and some force or trauma might have caused the bone fracture.

During interview, a leadership member stated he reviewed previously recorded video of multiple memory care cameras of the day before the resident's injury until the morning staff found the resident with injuries, and no unusual activity was noted in the hallway.

The recorded video footage was not retained by the facility.

During separate interviews, unlicensed staff members stated they did not see or experience anything unusual regarding the resident's care. The unlicensed staff members stated they did not have knowledge of how the resident's femur broke.

During separate interviews, family members stated the surgeon who performed the resident's surgery indicated the resident's bones were decalcified to the point of being foam like and rubbery. Family members stated the surgeon indicated the break could have happened with a slide into bed or general movements.

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

Action taken by facility:
Facility conducted an internal investigation of the incident.

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
	34716	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARDS OF MINNETONKA	10955 WAYZATA BOULEVARD MINNETONKA, MN 55305

(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 30, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL347161819C/#HL347162602M. No correction orders are issued.	0 000		