Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL352309044M
Compliance #: HL352307342C

Date Concluded: April 16, 2025

Name, Address, and County of Licensee Investigated:
Urbana Place Senior Living
5601 94th Avenue N.
Brooklyn Park, MN 55443
Hennepin County

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

Evaluator's Name: Michele Larson, 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 two residents (resident #1, resident #2) when they failed to provide adequate supervision. As a result, resident #2 assaulted resident #1 causing multiple injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the memory care unit was short one staff that evening, facility staff provided care to resident #1 and resident #2 according to their care plan. It could not be determined if the incident could have been prevented with one additional staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident #1 and resident #2's family members and resident #2's case manager. The investigation included review of resident records, hospital records, facility internal investigation, facility incident reports, personnel files,

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

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included early onset Alzheimer's disease. Resident #1's service plan included assistance with toileting, escorts, medications, meals, personal cares, and safety checks. Resident #1's assessment indicated resident #1 was not oriented to person, place, or time, was unable to express her needs, exhibited poor judgement with impaired decision making. Resident #1 was unable to report abuse or neglect. Resident #1 walked independently and wandered.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia. Resident #2's service plan included assistance with toileting, escorts, medications, meals, and personal cares. Resident #2 received three scheduled safety checks at 3:00 a.m., 6:00 a.m., and 11:30 p.m. Resident #2 was forgetful, confused with poor/impaired decision making, and memory loss. Resident #2 was prescribed an antipsychotic medication scheduled three times a day for his agitation and anxiety. Resident #2's apartment door was kept locked from the outside to prevent other residents from wandering into resident #2's room. Resident #2 was able to leave his room independently. Resident #2 had impaired short-term memory and was unable to recall events. Resident #2 was unable to report abuse or neglect. Resident #2 used a walker for mobility and a wheelchair for longer distances.

Resident #1's progress note indicated one evening staff documented resident #1 experienced an unwitnessed fall in another resident's bathroom. Resident #1 was unable to tell staff what happened. Staff found resident #1 in the common area bleeding from head wounds to the top and back of her head; blood dripped down her face and neck. Skin tears and cuts were noted on resident #1's forearms and fingers and resident #1's left pointer finger was discolored and swollen.

Later, staff reviewed the facility's recorded video. After review of the video, facility staff notified the on-call triage nurse to report the video showed resident #1 entering resident #2's room. The on-call triage nurse advised the nurse to complete an incident report, place a door alarm on resident #2's room door, obtain vitals, and see if resident #2 needed to be evaluated at a hospital if he became a risk to himself. The on-call nurse contacted resident #2's primary provider about the incident and requested a change in resident #2' s antipsychotic medications.

Resident #2's progress note indicated the day of the incident, at an unknown time, the resident exhibited increased confusion when he stated he needed to get to the third floor because "Someone is coming to get me." Resident #2 was unable to be redirected and adamantly refused any assistance with his bedtime routine but took his medication without concern and went to bed.

The facility's internal investigation report indicated the day of the incident, at 7:44 p.m., resident #1 was seen on facility camera footage entering resident #2's apartment. An hour

later, resident #2 left his apartment and four minutes later resident #1 was seen exiting resident #2's apartment. A few minutes later facility staff found resident #1 in the hallway with blood on her clothes and hair. Resident #1's family members arrived and transported the resident to the hospital for evaluation. After the incident, staff activated door alarms on resident #1 and resident #2's room doors. Resident #2's antipsychotic medication dose was increased with an additional as needed dose. Staff education included ensuring resident #2's door was locked when leaving his apartment, conducting safety checks according to the resident's service plans, and frequent staff rounding in the memory care unit. Causative factors contributing to the incident included resident #1 was able to enter resident #2's unlocked room door.

Resident #1's hospital record indicated resident #1 injuries included: a significant hematoma (swelling or lump caused by a collection of blood due to trauma or injury) to the occipital (back) of her head as well as superficial lacerations (cuts), abrasions (friction rubbing of skin) to her front chest and arms, scratch marks from a hand over her left shoulder, and bruising on her body. X-rays of her left hand indicated her left pointer finger was fractured. Due to resident #1's impaired cognition, the head wound was repaired using minimally invasive procedures. Resident #1 was discharged back to the facility.

Review of the facility staff schedule indicated three unlicensed personnel were scheduled to work the memory care unit for the evening shift instead of the normal schedule of four unlicensed personnel.

During an interview, an unlicensed personnel stated between 7:00 p.m. and 7:30 p.m. she provided resident #2's cares then locked his door and went to resident #1's apartment to prepare the resident for bed. The unlicensed personnel stated resident #1 frequently wandered and was "so" fast, stating after putting her to bed, resident #1 was able to leave her room and enter resident #2's apartment unnoticed. The unlicensed personnel stated although they were short staffed she and other unlicensed personnel worked together to provide services for the residents.

During an interview, a facility nurse stated resident #2 felt comfortable and safe inside his apartment, was sometimes quiet and not a problem, but other times could be easily angered, yell, and aggressive around dinnertime. The facility nurse stated after the incident they were able to remove most of the blood from of resident #1 and keep her calm, stating resident #1 seemed okay and her vital signs were normal. The nurse stated she asked the three unlicensed personnel who worked in the memory care unit where they were when the incident happened, stating one unlicensed personnel was performing cares and giving medications to other residents and the other two unlicensed staff were completing two resident showers.

During an interview, leadership stated she immediately reviewed camera footage after the incident and saw resident #1 wandering the hall looking for an unlocked apartment door. Leadership stated staff were in the hallway walking by resident #1 but stated resident #1 was not trying to enter a resident's apartment. Leadership stated as soon as staff walked down

another hallway resident #1 walked over to resident #2's apartment door and opened it. Leadership stated after resident #2 and resident #1 left resident #2's apartment, within minutes of each other, they crossed paths in the hallway. Resident #1 did not appear afraid and resident #2 showed no signs of aggression. Leadership stated after the incident they put door alarms on both residents' doors to alert staff when the residents left their apartments, increased monitoring of facility camera footage, and increased resident #2's behavior medication.

During an interview, resident #1's family member stated she complained to leadership about staffing issues and having staff in the common area while other staff prepare other residents for bed.

During an interview, resident #2's family member stated Resident #2 did not recall the incident stating staff reported resident #2 did not appear injured but was "out of it." Resident #2's family member stated she recognized even though the residents were on frequent safety checks something could still happen.

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. Unable to interview both residents due to impaired cognition.
Family/Responsible Party interviewed: Yes. Both resident's family members were interviewed.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility conducted an internal investigation. After the incident, both residents received increased safety checks and door alarms, and Resident #2's antipsychotic medication was adjusted.

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
	35230	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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: #HL352307342C/#HL352309044M #HL352307721C/#HL352309202M #HL352307767C/#HL352309222M On March 13, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 87 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL352307721C/#HL352309202M, tag identification 2310 and 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a facility licensed practical nurse (LPN)-A, reported a pressure sore to one of one resident (R1)'s medical provider to initiate orders for home health management of R1's wound. LPN-A was instructed twice by licensed assisted living director (LALD)-C and registered nurse (RN)-B to evaluate and update R1's medical provider. LPN-A evaluated R1's pressure sore but failed to update R1's medical provider which led to a delay in initiating R1's wound care for several weeks. R1 developed an unstageable pressure sore requiring weeks of weekly wound care. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record was reviewed. R1 was admitted to the licensee's facility on August 6, 2021. R1's diagnoses included severe protein-calorie malnutrition. R1's service check off list dated December 2024 indicated R1 received	02310		

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02310	Continued From page 2 assistance with personal cares, toileting, safety checks, and escorts. R1 used a wheelchair for mobility and a sit to stand lift for transfers. R1's assessment dated December 19, 2024, indicated R1 had limited range of motion, impaired mobility, and weakness. R1 had no skin issues at the time she was assessed. R1's progress note dated December 30, 2024, at 2:57 p.m., indicated LPN-A was informed R1 had an open wound on a leg. R1 denied having a wound and refused to have LPN-A assess her legs. R1's progress note lacked documentation LPN-A made additional attempts to assess R1's legs or communicated with facility leadership R1 refused to be assessed. R1's record indicated no additional information was documented about R1's wound until two weeks later. R1's progress note dated January 16, 22025 at 6:03 p.m., documented by LPN-A, indicated LPN-A attempted to reassess R1's legs as previously requested by LALD-C on December 30, 2024, but R1 refused stating she had no skin issues on her legs. No further reattempts were documented by LPN-A, or documentation LPN-A asked another floor nurse to assess R1, or update RN-B, LALD-C, and R1's medical provider. R1's progress note dated January 17, 2025, at 10:13 a.m., documented by registered nurse (RN)-B, indicated a wound was noted to R1's left outer ankle. LPN-A's measurements of R1's wound indicated the wound was 2 centimeters (cm) x 1.5 cm x 0.3 cm. No further description of R1's wound was documented. RN-B indicated	02310		

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02310	Continued From page 3 LPN-A would follow-up with R1's medical provider to notify them of R1's wound and request recommendations and request for referral to home health agency for wound assessment and management. R1's record lacked documentation LPN-A contacted and updated R1's medical provider about R1's wound and to initiate wound care for R1's pressure sore. R1's progress note dated February 7, 2025, at 9:19 a.m., indicated RN-B contacted R1's medical provider to provide an update on R1's wound and to request a home health wound evaluation. RN-B indicated R1's medical provider was never notified about R1's wound until RN-B called and updated the provider. R1's progress note dated February 7, 2025, at 10:54 a.m., documented by RN-B, indicated upon review of R1's record, there were no progress notes documented by LPN-A indicating she followed up with R1's medical provider or notes a current treatment plan was implemented for R1's pressure sore. New measurements obtained of R1's wound indicated the length, width, and depth of the wound increased, measuring 2 cm x 2 cm x 0.5 cm. RN-B indicated R1's pressure sore appeared to be a full-thickness, stage 3 wound with adherent sloughing (presence of necrotic, dead tissue). R1's progress note dated February 13, 2025, at 1:16 p.m., indicated home health began treatment for R1's pressure sore on February 13, 2205, at 2:30 p.m. During an interview on March 20, 2025, at 8:11 a.m., LPN-A stated on December 30, 2024,	02310		

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02310	Continued From page 4 LALD-C requested she evaluate a wound found on R1's leg by unlicensed personnel (ULP). LPN-A stated an ULP said R1 had a wound on her leg but did not state the location of R1's wound. LPN-A stated R1 became angry when LPN-A asked R1 if she could look at R1's leg wound, stating R1 insisted she did not have a wound. LPN-A stated she documented R1's refusal and told LALD-C R1 did not have a wound. LPN-A admitted she never made further attempts to assess R1's wound after R1 first refused. LPN-A stated on January 16, 2025, RN-B asked her to assess and obtain measurements of R1's wound. LPN-A stated she took measurements of R1's wound and handed the measurements to RN-B, stating she assumed RN-B would update R1's medical provider since RN-B asked her for the measurements of R1's ankle wound, even though she acknowledged it was one of her nursing duties. LPN-A stated she resigned because of R1's wound incident in addition to an issue regarding a misplaced order, stating she felt badly treated by facility leadership. During an interview on March 31, 2025, at 11:00 a.m., RN-B stated she began working at the facility on January 6, 2025, one week after R1's pressure sore was first discovered. RN-B stated floor nurses were expected to monitor and update nursing leadership whenever a resident experienced a change in condition, stating she often delegated tasks to floor nurses. RN-B stated on January 16, 2025, she received a "Wisdom to Act" notice from an ULP indicating a wound concern on R1's ankle requiring a nurse follow-up. RN-B stated she immediately asked LPN-E to obtain measurements of R1's ankle wound then follow-up with R1's medical provider for an order for home health referral. RN-B stated on February 7, 2025 she received another	02310		

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02310	Continued From page 5 "Wisdom to Act" notice from an ULP inquiring if RN-B was aware of R1's ankle wound or if it was addressed. RN-B stated she immediately contacted R1's medical provider, measured R1's ankle wound, took photos, and updated regional nursing leadership. RN-B stated she took accountability for not following up with LPN-A but stated she fully expected LPN-A to complete the nursing task because LPN-A told her she would do so. During an interview on April 1, 2025, at 3:00 p.m., LALD-C stated on December 30, 2024, she requested LPN-A assess a wound on R1's leg reported to her by an ULP and follow facility protocols for wound orders. LALD-C stated on February 7, 2025, she found out LPN-A never updated R1's medical provider or obtain orders for wound care, so she immediately conducted an internal investigation. LALD-C stated LPN-A admitted she did not make any further attempts to try and assess R1's wound before she documented R1 refused, stating LPN-A seemed to not understand she needed to make two additional attempts to assess R1's wound. LALD-C stated nursing leadership retrained LPN-A on wound care but stated shortly after RN-B found unprocessed orders stacked in the nurse's station LPN-A and two other LPN's overlooked. LALD-C stated LPN-A worked multiple day and evening shifts during the time the orders came through. LALD-C stated LPN-A refused to listen or take any responsibility for the orders not being completed. LALD-C stated the two other LPN's were suspended then retrained on processing orders stating the other LPN's took responsibility and seemed remorseful. LALD-C stated LPN-A resigned before she could be terminated.	02310		

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02310	Continued From page 6 The licensee policy titled Wound Care and Pressure Injury, updated August 2023, indicated the nurse was to notify the resident's physician as soon as possible but not to exceed 24 hours whenever a resident was assessed with alterations in skin integrity. No additional information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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 one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		