Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392684164M
Compliance #: HL392687128C

Date Concluded: October 20, 2023

Name, Address, and County of Licensee Investigated:
Norbella Senior Living
2025 Michaud Way
Centerville, MN 55038
Anoka County

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

Evaluator's Name: Julie Serbus, 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 alleged perpetrators (APs), three unlicensed caregivers, neglected the resident when the APs failed to follow the resident's care plan and provide safety checks and comfort cares over the night shift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although, the resident passed away, the resident was on hospice cares was expected to decline based on her hospice diagnosis. The investigation found insufficient evidence the resident's cares were not provided nor evidence it affected the outcome for the resident. A care plan was created for services the resident required and the APs documented the tasks were completed on their shift.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted a family member. The investigation included

review of the resident's medical record, employee records, facility policy and procedures. Also, the investigator completed an onsite visit.

The resident resided in an assisted living facility. The resident lived alone in her own apartment. The resident's diagnoses included encephalopathy (damage or disease that affects brain function), respiratory failure, and kidney disease. The resident's care plan included safety checks, repositioning, and incontinence care every two hours. The same care plan failed to indicate staff should also perform tasks "as needed." The resident's care plan also indicated the resident was bed bound with limited speech, non-ambulatory, weakness related to dying process, and fully dependent on two staff for bed mobility.

The resident's admission assessment indicated resident did not report pain and skin was intact. This same assessment indicated resident currently in the dying process and on hospice services.

The nursing progress note indicated the day shift staff entered the resident's room for morning rounds and found the resident unresponsive. The facility nurse was notified, assessed the resident, and found the resident to be deceased.

The facility investigation notes indicated facility management called the alleged perpetrators who worked the overnight shift to discuss that the resident was found by day shift caregivers passed away. Facility management inquired of the APs if overnight cares had been provided according to the care plan. The same document indicated each of the APs said the care plan had been followed and there were no concerns to report off to the next shift.

The same facility investigation notes indicated from the time of the last safety check until the time of the next safety check to be completed by morning staff there was a little over two-hour period where staff did not have scheduled checks on the resident.

A review of licensed staff member's written statement indicated she assessed the resident not to be breathing, cool to touch, and based on physical observation of the resident concluded overnight staff had not completed scheduled tasks for this resident.

The electronic documentation of cares indicated overnight staff documented four times performed safety checks/cares staff checked on the resident in correlation to care plan.

A review of the overnight shift communication report indicated the resident was stable.

During interviews, separately each one of the APs stated the resident acknowledged when staff were in the room during rounds as indicated with eye contact or wave of the hand. The staff stated no safety checks had been missed and all tasks were completed every two hours as care planned.

During an interview, facility administration stated no video cameras are present in the assisted living side of the facility nor was there a camera present in the resident's room.

During an interview, an unlicensed caregiver stated communication between shift changes occurs both verbally and in writing. The same caregiver stated when staff come on shift, they receive report, prepare for the shift, and thereafter, start safety checks on residents.

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: Yes

Action taken by facility:
The alleged perpetrators are no longer employed at the facility.

Action taken by the Minnesota Department of Health:
No further action.

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
	39268	A. BUILDING: _____ B. WING _____	C 06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA CENTERVILLE	2025 MICHAUD WAY CENTERVILLE, MN 55038

(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 June 28, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL392687128C/#HL392684164M. No correction orders are issued.	0 000		