Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306689602M
Compliance #: HL306688902C

Date Concluded: March 20, 2025

Name, Address, and County of Licensee Investigated:
Tamarack Court of Bemidji
1511 Delton Avenue NW
Bemidji, MN 56601
Beltrami County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 perpetrator (AP), an unlicensed personnel (ULP) at the facility, neglected the resident when he failed to provide services as directed by the service plan. The AP documented he brought the resident to the bathroom; however, security camera footage showed the AP never entered the room. The resident fell and broke her hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It could not be determined whether the AP's failure to complete scheduled toileting and a safety check resulted in the resident's fall. When staff found the resident on the floor, staff contacted the nurse, and the resident was sent to the emergency room for evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, hospital records, facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and orthostatic hypotension (low blood pressure that happens when standing after sitting or lying down). The resident's service plan included assistance with toileting and safety checks. The resident's assessment indicated the resident was at risk for falls. The resident had scheduled safety checks due to confusion and staff were to anticipate needs.

The incident report indicated the resident was found on the floor of her living room around 4:00 a.m. The resident wasn't able to describe what happened, but staff assumed the resident was trying to stand up from her chair and fell. The resident couldn't move her left leg without severe pain so the nurse and 911 were called. The resident was taken to the emergency room.

Hospital records indicated the resident was brought to the emergency room for evaluation after a fall where she had been on the floor for about 20 minutes. The resident was diagnosed with a left femoral neck fracture (an injury where the ball on the top of the femur/leg bone has broken within the hip joint) which required surgical repair. The resident was transferred to a skilled nursing facility.

The facility's internal investigation indicated the AP documented he completed toileting and a safety check at 4:14 a.m., however camera footage showed staff last left the resident's room at 2:28 a.m. Camera footage showed staff found the resident on the floor at 4:25 a.m. Staff working at the time of the fall were interviewed by facility management and the AP was placed on administrative leave pending investigation. The AP received a written warning for false documentation and was reeducated on appropriate documentation and following the care plan and vulnerable adult policy. All employees were retrained on the importance of accurate documentation and the vulnerable adult policy.

The AP's employee record indicated he received appropriate training and orientation to the licensee's policies and procedures. The AP did not have a history of disciplinary actions.

During an interview, a facility nurse stated she was called after the resident fell and directed staff to send the resident to the emergency room. The nurse stated staff reported the resident was restless that night, but it was still within her normal behavior patterns. The nurse stated as they were investigating the fall, it was identified the AP documented services as completed but camera footage showed staff did not enter the resident's the room. The nurse stated they met with the AP who was very remorseful over what happened, and he was retrained on facility procedures for documentation.

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: Unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Attempted

Action taken by facility:
The facility investigated the root cause of the resident’s fall and through the investigation identified that the AP failed to enter the resident’s room to perform scheduled toileting and a safety check. The facility suspended the AP and completed an internal investigation. The AP was retrained, and all facility staff received training on documentation. The facility conducted audits to ensure documentation accurately reflected services provided. The facility reported the incident to MAARC.

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
	30668	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK COURT OF BEMIDJI	1511 DELTON AVENUE NW BEMIDJI, MN 56601

(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 March 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306689602M/#HL306688902C. No correction orders are issued.	0 000		