Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54481622M
Compliance #: H54481520C

Date Concluded: June 12, 2025

Name, Address, and County of Licensee Investigated:
Park River Estates Care Center
9899 Avocet Street NW
Coon Rapids, MN 55433
Anoka County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual 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 resident was neglected when The Alleged Perpetrator (AP), an unlicensed personnel (ULP), failed to transfer the resident according to her plan of care. The AP transferred the resident alone, causing the resident to scream out in pain and have swelling in her right arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the resident's plan of care which instructed staff to use a full body mechanical Hoyer lift and 2 staff assistance with all transfers. The AP pivot transferred the resident from her bed to wheelchair alone causing the resident to flop into her wheelchair and instantly scream out in pain. A radiology report showed the resident sustained a fracture of her right arm during the transfer. The resident's record of death indicated the resident died 2 days later related to complications from the fracture.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, radiology reports, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures, and previous federal investigation documentation.

The resident resided in a skilled nursing facility with diagnoses including osteoarthritis, history of falling, and age-related osteoporosis without pathological fractures.

The resident's assessment completed approximately one month prior to the incident indicated the resident was cognitively intact, required extensive physical assistance from one staff with bed mobility, and was totally dependent on 2 staff physical assistance for transfers.

A physical therapy (PT) assessment about one month prior to the incident indicated the resident was referred to therapy following a decline in bilateral lower extremity strength causing a loss in standing and transferring function requiring the use of a full body mechanical Hoyer lift for transfers. The assessment indicated the resident was at a risk for falls, had a fear of falling, and felt unsteady. The assessment indicated the resident was unable to stand, and despite therapy interventions could not tolerate standing for transfers. The PT assessment indicated the resident should continue to use a full body mechanical Hoyer lift for all transfers.

The resident's plan of care indicated the resident was unable to ambulate and required assist of 2 staff and a mechanical lift for transfers. The resident's care guide, (an abbreviated plan of care for staff to carry that contained pertinent resident information like transfer status), indicated the resident required 2 staff assistance and a full body mechanical Hoyer lift with a purple sling for transfers.

A review of the resident's point of care documentation for transfer assistance from the date of her PT assessment until the incident, showed the AP documented transferring the resident using the full body mechanical Hoyer lift using 2 staff assistance 2 times prior to the day of the incident.

The resident's progress notes the day of the incident indicated a nurse heard the resident yelling and responded to find the resident seated in her wheelchair holding and pointing to her right arm crying. The notes indicated when the resident was asked what happened she reported she fell during the transfer. The notes indicated the resident's arm appeared swollen above the elbow, and the resident was unable to move the arm. The resident's provider was notified, and an Xray was ordered.

A facility incident report indicated nursing staff heard the resident yelling, a nurse checked on the resident and observed the resident pointing to her right arm crying. The report indicated when the nurse asked the resident what happened, the resident stated she fell during the

transfer with the AP. The report identified factors contributing to the incident included weakness, and imbalance during a transfer.

A radiology report the day of the incident, identified the resident sustained a comminuted (when a bone shatters in 3 or more pieces) oblique (at an angle to the bone shaft) fracture of the right distal humeral shaft (upper arm above the elbow).

Facility investigation documentation indicated the AP denied the resident had any unusual pain or swelling in her right arm during morning cares prior to the transfer. The investigation indicated a nurse who applied pain ointment to the resident's shoulders and upper arm area also indicated the resident had no unusual pain or swelling prior to the AP transferring the resident. The investigation indicated the resident told the AP she needed to use a Hoyer to transfer her, but the AP denied that occurred, and indicated she was not aware the resident required a full body mechanical Hoyer lift for transfers. The AP denied checking the resident's plan of care or care guide prior to transferring the resident. The AP stated she placed a transfer belt on the resident and indicated the resident's arms hung at her sides during the transfer. The AP stated the resident said, "ouch you're hurting me" during the transfer, then "screamed in pain" when the AP put the resident into her wheelchair. The investigation indicated when the resident screamed out in pain another nurse responded to check on the resident. The nurse stated the resident was seated in her wheelchair screaming in pain that could be heard down the hallway. The nurse observed the resident's right arm between the bed and the arm rest of the wheelchair. The nurse identified the resident's right arm was swollen above the elbow and looked like it may be broken. The facility investigation indicated the nurse assisted the AP to transfer the resident back into bed and identified the resident's injury occurred during the transfer with the AP.

When interviewed facility leadership indicated staff were trained and expected to check and follow the resident's plan of care, but the AP did not. Leadership indicated although the resident stated she fell; she had not fallen on the floor but flopped into the wheelchair during the transfer with the AP. Leadership indicated the resident immediately screamed out in pain and sustain a fracture as a result of the incident.

A review of the AP's personnel files and training records indicated the AP was trained and competent to provide care and services including transfer assistance using a full body mechanical Hoyer lift at the time the incident occurred.

When interviewed during a previous federal investigation the AP described transferring the resident and indicated the resident flopped falling backward into her wheelchair, then immediately screamed out in pain saying she was hurt. The AP stated the resident's care guide and care plan indicated she required a full body mechanical Hoyer lift and 2 staff assistance with transfers, but the AP did not follow the plan of care the day the incident occurred.

When interviewed one nurse stated the AP was assisting the resident to get ready for the day when she entered the room to apply pain cream to her shoulders and upper arms. The nurse stated the resident had no unusual pain or swelling in her arm at that time. Then, a few minutes later she and another nurse heard screaming, and the other nurse went to check on the resident.

When interviewed the other nurse stated she heard screaming and immediately went to check on the resident. When she got near the resident's room the AP opened the door and asked for help. The nurse stated the resident was seated in her wheelchair with a transfer belt around her waist and the mechanical Hoyer lift was observed in the room. The nurse stated the resident appeared to be in severe pain with her arm between the wheelchair arm rest and the resident's bed. The nurse stated after the transfer with the AP the resident's upper arm was swollen, and the resident was unable to move her arm.

When interviewed one unlicensed personnel (ULP) stated she had observed the AP not following another resident's plan of care for transfer assistance prior to the incident. The staff stated she had observed the AP transferring another resident alone using a full body mechanical Hoyer lift which always required 2 staff assistance.

When interviewed the AP stated she did not review the resident's care plan/care guide the day of the incident. The AP indicated she was not aware the resident required a full body mechanical Hoyer lift and 2 staff assistance for transfers. The AP described transferring the resident alone and indicated the resident flopped into the wheelchair then screamed out in pain. The AP denied ever transferring or assisting to transfer the resident with 2 assist and a Hoyer prior to the incident.

When interviewed the resident's family stated the AP neglected to transfer the resident according to her plan of care causing the resident to sustain a fracture. The family member stated the resident suffered in pain, then died as a result of her injury.

The resident's death record indicated the resident died 2 days after the incident occurred from complications related to the humerus fracture.

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, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP, investigated the incident, re-educated all staff, and implemented additional transfer status communication for staff. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department
Department of Human Services (DHS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00010	A. BUILDING: _____ B. WING _____	C 05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK RIVER ESTATES CARE CENTER	9899 AVOCET STREET NORTHWEST COON RAPIDS, MN 55433

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54481622M/#H54481520C in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 are issued for #H54481622M/#H54481520C, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as	21850		

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21850	Continued From page 2 authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 1 resident's (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that a individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public report.	21850		