Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL273989562M
Compliance #: HL273988840C

Date Concluded: June 5, 2025

Name, Address, and County of Licensee Investigated:
Ecumen Seasons at Maplewood
1670 Legacy Parkway East
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when the facility used an unapproved standing lift sling. The resident fell from the standing lift and fractured her back.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to properly measure the resident for the correct size standing lift sling. The facility gave the resident a green, size large sling to use for transfers. The facility based the sling size only on weight. According to the mechanical standing lift sling size guide found on the manufacturer's website, the standing lift sling size was determined by measuring the resident's waist. Also, the resident voiced concerns about the sling size to staff and family not fitting right. The resident 's personal trainer also voiced concerns to staff that the sling the facility provided was too big. During a transfer the resident slipped out of the sling and fell to the floor fracturing her back.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and the mechanical standing lift representative. The investigation included review of the resident records, facility incident report, personnel files, staff schedules, mechanical standing lift manufacturer sling size guide manual, related facility policy and procedures. Also, the investigator toured the facility and observed mechanical lift machines, slings, and staff mechanically transferring residents.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis and osteoarthritis. The resident's service plan included transfer assistance with one staff and a mechanical standing lift.

The resident's progress note dated less than a week before the incident indicated nurse-2 discussed with the resident concerns the resident had with the standing lift sling. On the date of the incident, the progress notes indicated the resident slid out of the standing lift.

The facility incident report indicated the resident "slipped out" of the standing lift after she let go of the machine's handle during a transfer.

The resident hospital record indicated the resident suffered a mechanical lift fall three days prior. CT (computed topography) imaging showed an acute fracture of the spine. The resident was fitted for a back brace and discharged.

A progress note dated a few days after the incident indicated the resident was diagnosed with a fracture in her back and was transferred to a transitional care unit.

The resident's death record indicated she died approximately one month after the fall with cause of death as complications of back fracture secondary to a fall to the floor.

An undated Sling Color/Size Guide from the facility indicated a weight range for each size sling. A green, size large sling had a weight range of 154 to 264 pounds. A yellow, size medium sling had a weight range of 121 to 165 pounds. The resident weighed 158 pounds and fell into both size ranges.

A picture taken by the personal trainer of a sling that was in the resident's room and used by the resident for transfers showed the sling had a green border.

Two standing lift slings, one of which was used during the incident were provided to the investigator by facility management, nurse-1. A picture taken during the investigation of the slings shows both slings had a green border which indicate a size large. Both slings have been taken out of use.

The Sling Sizing and Measurement Guide found on the manufacture's website indicated a sling with a green border is a size large. The sizing guide also indicated the proper way to measure a

resident for the mechanical standing lift sling the resident used was by measuring around the waist.

During an interview, a family member said the facility called her and reported the resident fell but did not have any injuries. The family member, along with another family member visited her a couple days later and the resident complained of pain. The family requested the facility get a mobile x-ray done. She said the facility nurse “laughed” about their concern for a fracture. A couple days later the resident still complained of pain. The family member took the resident to the hospital, and she was diagnosed with a fracture in her back. She said the resident reported during the incident she told the staff member she was losing her grip, and the staff member told the resident she was “fine.” After the incident, the resident’s personal trainer called the family member and reported he was concerned about the size sling the facility gave the resident. He said the sling used was too big. The resident went to a transitional care unit following the fall and died a few weeks later.

During an interview, the resident’s personal trainer said he worked with several residents at the facility. He said the resident used a standing lift for transfers. She originally used a size small standing lift sling, but it was misplaced. After the facility misplaced the smaller sling, the facility used a larger sling. The resident said she was not comfortable in the larger sling because she could slip out of it. He took a picture of the larger sling the facility used to transfer the resident. The larger sling was in her room for over a month. He was unable to complete his treatments during this time as the sling was too big and a safety risk. He said he reported his concerns to staff at the facility and requested a replacement. He reported the sling was uncomfortable and not supporting the resident properly. He said the staff member he reported his concerns to agreed that the sling was too big, but they did not have a smaller sling available. The personal trainer offered to purchase a smaller sling with his own money because he was so concerned. A few days later the resident slipped out of the sling. She died a few weeks later.

During an interview, nurse-2 said she reported to nurse-1 the resident was weaker and should be reassessed to determine safety with using a standing lift. Nurse-2 said she was not familiar with assessing residents to use the standing lift or sizing them for slings. After the incident, nurse-1 asked if nurse-2 sized the resident for her standing sling. Nurse-2 told her “No” she only completed the 90-day assessment. Nurse-2 thought nurse-1 assessed the resident’s safety with the standing lift and fitted her for the correct sling size. The resident initially had two slings; both were different sizes. Nurse-1 removed one sling because another resident needed it. The resident repeatedly asked for the other sling back because the resident liked the fit better. Nurse-2 never received training on how to size a resident for a sling. After the incident, nurse-1 sent out information on how to size a resident for a sling. No training was provided, only a paper from the manufacture was given. Nurse-2 was never trained on how to assess if a resident was safe to use a standing lift. She said recently she observed a resident using the wrong size sling, so she gave him a different size based on his weight. She said the facility needed to buy more slings as there were multiple residents who needed the same size. The sizing guide in the nurse’s station had a weight range where the highest weight on the smaller

size is also the lower weight on the larger size. The sling size assessed for each resident was never listed anywhere for staff to see until after the resident fell. Likewise, there was never any information for how to size a resident for a sling until after the incident.

During an interview, unlicensed personal-2 who responded to a call for assistance after the resident fell said unlicensed personnel-1 reported the resident “slipped” from the standing lift. She said the resident usually used a green or a blue sling for transfers. She said the green sling was larger than the blue sling.

During an interview, unlicensed personnel-1 said the resident slipped completely out of the standing lift sling and fell to the floor. Before the resident fell, she complained of tiredness and knee pain. She said the resident did not like the sling pulled tight, but she thought she pulled it tight enough for safety. Unlicensed personnel-1 was unaware of where the sling size/color was identified for each resident. She used whatever slings were in the resident’s room at the time of transfer. She was unsure if she used the facility’s mechanical lift machine or the resident’s personal lift machine. She did not recall being trained on what lift to use if two mechanical lifts were in a resident’s apartment.

During an interview, nurse-1 who was also a member of management, said the resident originally used a standing lift machine and sling she privately purchased but after the facility purchased a mechanical standing lift the resident used the facility’s machine. The resident’s privately purchased machine and sling were stored in the resident’s apartment. She said the resident used a green, size medium sling for transfers. She said nurse-2 completed the resident’s assessment including safety using a standing lift and determined appropriate sling size. She said sling size was determined based on the resident’s weight. Nurse-1 said, “I know the green is a medium because it is the most common size.” She said slings used to stay in the resident’s room but now they are cleaned in between use and shared between residents. She said she completed the internal investigation but never interviewed the staff member after the resident fell and fractured her back.

During an interview, the mechanical lift representative reviewed the sizing guide and said the standing lift sling size was based on waist circumference. He said the machines and slings were built for people who cannot stand well. If the correct size sling was applied appropriately a resident would not slide out of a sling to the floor. During his demonstrations he lets go of the machine with his hands and lets his legs go limp to demonstrate how a resident would not fall to the ground. The manufacture’s guide and sling size guide was found on the manufacture’s website. There used to be a size guide based on weight but that was an old guide and was no longer used. The facility must assess the fit of each resident’s sling individually and ensure the resident felt safe and comfortable in the sling. The representative stated he represented a region and those facilities were to report any adverse event or fall from a lift and the facility did not report the event to him.

No further body measurements were taken to determine appropriate sling size fit despite several people voicing concerns.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility followed an erroneous order, direction or care plan with awareness and failure to take action.

The facility directed an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The facility followed the facility directive and/or policies and procedures.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reported the incident to family and completed an incident report.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in 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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27398	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

(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: HL273988840C/HL273989562M On May 14, 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 83 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL273988840C/HL273989562M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		