Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302845483M
Compliance #: HL302849398C

Date Concluded: August 21, 2023

Name, Address, and County of Licensee Investigated:
Champlin Shores
119 East Hayden Lake Road
Champlin, Minnesota 55316
Hennepin County

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

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Not Substantiated

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) neglected a resident when the AP left the resident alone while toileting. The resident fell and broke her pelvis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell while alone in the bathroom, the error was an isolated incident. The resident sustained a pelvic fracture, went to the hospital, then a transitional care unit (TCU), and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, facility incident reports, and policies regarding falls, emergencies, and vulnerable adults. The investigation also included review of the resident's hospital and hospice records, the AP's

personnel record, and the facility's internal investigation of the incident. Also, the investigator observed toileting and transfers.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included hands-on assistance with transfers and a gait belt. The resident's assessment indicated the resident used a manual wheelchair for mobility and assistance with toileting.

An incident report indicated the AP helped the resident onto the toilet and left her unattended. The AP came back and found the resident on the floor. The resident had a cut on her face and had thrown up. Staff sent the resident to the emergency department.

The hospital after visit summary indicated the resident received sutures for a cut on the head. The resident returned to the facility the same day.

Over the next two days, nursing notes indicated the resident had been complaining of right hip and low back pain. Nursing requested an x-ray from the provider. The provider requested to continue with pain medication, checking the leg length for discrepancy, and using ice packs. The pain continued, and nursing followed up with the provider. The provider ordered the x-ray.

The following morning, results from the x-ray came in which showed a broken pelvis. Nursing notified the provider group who recommended hospitalization. Nursing staff spoke with family and sent the resident to the hospital.

The resident admitted to the hospital, then transferred to a TCU before returning to the facility.

During an interview, a nurse stated she went to the resident's bathroom after being called by staff and found the resident lying on the floor with a cut on her head. The resident had thrown up as well. The nurse assessed the resident, ensured comfort, and called 911. The nurse stated nursing notified the provider and requested an x-ray when the resident started complaining of pain.

During an interview, a family member stated communication with her from the facility should have been better.

During an interview, the AP stated the resident wanted to use the bathroom before bed. The AP helped the resident onto the toilet and waited in the bathroom. The resident requested privacy, so the AP stood outside the bathroom door with the door halfway closed. After the resident toileted, the AP went back into the bathroom to help but realized there were no wipes. The AP went into the resident's bedroom to look for wipes. While the AP looked for wipes, she heard the resident fall. She immediately went back into the bathroom and found the resident on the floor. The AP notified the medication passer who called the nurse.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.
Insert maltreatment definition here.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The facility obtained medical care for the resident after the fall. AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30284	A. BUILDING: _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPLIN SHORES	119 EAST HAYDEN LAKE ROAD CHAMPLIN, MN 55316

(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 LICENSING 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: #HL302849398C/#HL302845483M On July 14, 2023, 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 85 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL302849398C/#HL302845483M, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Licensing 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 provide care as required by the service plan, for one of one residents (R1) reiewed for a fall with significant injury. Unlicensed personnel (ULP)-C failed to remain with R1 while providing toileting assistance when R1 fell and fractured her pelvis. 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 diagnoses included Alzheimer's disease. R1's service plan dated March 19, 2023, indicated R1 received assistance with all personal hygiene needs and required routine hands-on assistance with transfers using a transfer belt. This service plan indicated R1 used a manual wheelchair for mobility. An incident report dated February 17, 2023, indicated ULP-C assisted R1 onto the toilet to void and left her unattended. ULP-C returned to the bathroom and found the resident on the floor.	02310		

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02310	Continued From page 2 Staff sent R1 to the emergency department. A nursing note on February 18, 2023, at 10:01 a.m., indicated R1 reported ongoing right hip pain. Staff updated the provider. A nursing note on February 20, 2023, at 8:23 p.m., indicated R1 continued to complain of hip and low back pain. Staff notified the provider who ordered a lumbosacral and pelvic x-ray. A nursing note on February 21, 2023, at 7:48 p.m., indicated an x-ray found an interval nondisplaced fracture of the inferior medial right pubic ramus. Nursing staff notified the provider who recommended hospitalization. A nursing note on February 22, 2023, at 5:32 p.m., indicated staff verbally re-educated ULP-C to stay with residents during cares, make sure to complete the cares, and have residents in a safe place and position at all times. A nursing note on March 21, 2023, at 12:59 p.m., indicated R1 re-admitted to the licensee after going to a rehabilitation facility following the hospitalization for the pelvic fracture. During an interview on July 14, 2023, at 10:20 a.m., ULP-F stated at no time would it be appropriate to leave while a resident remained on the toilet. For residents who were higher fall risks, ULP-F stated he stayed in the room where the resident could still be seen but also have some privacy. During an interview on August 14, 2023, at 8:03 a.m., ULP-C stated R1 wanted to use the bathroom before bed. ULP-C helped R1 onto the toilet and waited in the bathroom. R1 requested	02310		

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02310	Continued From page 3 privacy, so ULP-C stood outside the bathroom door with the door halfway closed. After R1 toileted, ULP-C went back into the bathroom to help but realized there were no wipes. ULP-C went into R1's bedroom to look for wipes. While ULP-C looked for wipes, she heard R1 fall, and she immediately went back into the bathroom and found the resident on the floor. ULP-C notified the medication passer who called the nurse. The licensee-provided competency Toileting Assistance, undated, lacked verbiage indicating staff were required to stay with the resident while providing toileting assistance. The licensee-provided policy Fall Risk & Prevention, dated October 27, 2022, lacked verbiage indicating staff were required to stay with the resident while providing toileting assistance. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		