Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report: HL307803303M
Compliance: HL307805335C

Date Concluded: May 28, 2023

Name, Address, and County of Licensee Investigated:
Minnehaha Senior Living
3733 23rd Ave S
Minneapolis, MN 55407-3598
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 failed to set up the orthopedic follow-up appointment after the resident's hospitalization. The facility also let the resident sit in his four-wheeled walker instead of a wheelchair for his doctor's appointment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's family chose to arrange transportation to appointments and, while there was some difficulties, the resident did get to the orthopedic for follow-up. The resident did arrive at the clinic with a walker instead of a wheelchair, however the resident did not own a wheelchair at the time and there was miscommunication regarding the appointment.

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 a review of the resident's records, the facility's policies and

procedures, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included heart failure and osteoarthritis. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The resident's assessment indicated he required assistance of one person for transfers and used a walker when ambulating. He was also on safety checks.

The resident's progress notes indicated one evening an unlicensed caregiver heard the resident yell and entered his apartment to find him on the floor. The resident complained of left arm and left hip pain, so the facility transferred him to the emergency room (ER). The same documents indicated he returned to the facility the next morning although the resident continued to complain of left shoulder pain for which he had pain medication prescribed on an "as needed" basis. The facility updated his nurse practitioner (NP) and contacted the resident's family regarding transportation to a follow-up orthopedic appointment to follow-up on his fall.

Over the next week the resident's medical records indicated the resident continued to have shoulder pain for which the facility gave him pain pills. The same documents indicated the NP assisted the resident's family with scheduling transport for an orthopedic appointment. About a week later the resident went to the appointment although there was a miscommunication with sending paperwork with him for the appointment once the facility was alerted the documents were faxed to the clinic.

Four weeks after the resident's fall the resident had a second orthopedic appointment for which the resident arrived at the clinic without a wheelchair but rather his four-wheeled walker, which was a concern because he was unsteady on his feet, so it was necessary for him to sit on his walker and be pushed for mobility.

During an interview, an unlicensed caregiver stated the resident was a high fall risk and needed to be checked for 10-15 minutes. She said he used the walker to ambulate and used the wheelchair for his outside appointments.

During an interview, a licensed social worker stated the resident she was aware the resident went to an appointment without a wheelchair but instead used a walker. She stated the resident did not have a wheelchair of his own when this occurred, but the resident has since received his own wheelchair.

During an interview, a nurse stated the family took care of the resident's appointments. He said the resident used the four-wheel walker for walking and used the wheelchair when he was out for his appointment. He said he did not know the resident had an appointment, so he did not send the paperwork with him.

During an interview, a director of health service stated the resident prefer to use the four-wheel walker because he could sit down on it. She said the hospital made the appointment and the family arranged the transportation for the resident. She also said the family was involved and she would help out as needed. She also said arrangement for transportation and appointment was not in the resident's service plan.

During an interview, a family member stated she the resident was in the memory care unit and the staff checked on him often. She said one time the facility sent the resident out to his appointment with his walker instead of using the wheelchair. She did not know why the facility would do this since it was not safe for him to be in the transport van with his walker however it only happened only once. She also said she was the one who made all the appointments for him. There was a transport van to take him to his appointment and she would wait for him there. Overall, she did not have concerns with his care at the facility.

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.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	30780	A. BUILDING: _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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 3/29/2023, the Minnesota Department of Health initiated an investigation of complaint HL307805335C/HL307803303M. No correction orders are issued.	0 000		