Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343206304M
Compliance #: HL343201961C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:
Mill City Senior Living
1520 17th St NW
Faribault, MN 55021
Rice County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 a resident when staff did not answer the resident's call light in a timely manner. The resident's leg got stuck in the wheelchair, and in an attempt to free herself, she pulled her leg, resulting in a lower leg injury that required 23 stitches in the emergency room (ER).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident sustained a leg injury during an attempt to self-transfer, the facility staff members did respond to her call light, but the injury had already occurred.

The investigator conducted interviews with the resident's family member and case manager. The investigation included review of resident's records. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living building. The resident's diagnoses include Parkinson's disease. The resident's service plan indicated the resident used a wheelchair for mobility and required assistance with transfers. The resident used the call light to summon caregivers for assistance as needed.

The resident's assessment indicated she was required to use assistive devices for mobility and depended on others to walk or push wheelchair. The assessment also indicated the resident was alert and oriented.

On the day of the incident, the resident self-transferred and accidentally got her left leg caught underneath her wheelchair, resulting in a laceration on her left shin. The resident pushed the pendant for help, and coincidentally, her family member arrived. She took the resident to the ER, where she received 23 stitches for the injury.

Based on the resident's progress notes, the nursing staff attended to the wound post-incident and maintained follow-up with the healthcare provider as required. Additionally, the nursing staff engaged in a discussion with the resident regarding her concerns about the wheelchair, given that her leg was frequently caught in it. The facility staff proactively contacted the wheelchair company to arrange an evaluation for a potential switch to a different chair.

The facility underwent a management change and was unable to provide the staff schedule on the day the incident occurred. Consequently, no staff members who worked that day could be conducted.

During an interview, a case manager reported being informed about the incident from the resident. According to her account, she attempted a self-transfer and inadvertently got her leg trapped in a part of her wheelchair. The resident mentioned calling for staff assistance, but they did not respond promptly; however, she did not specify the duration of the wait. Eventually, she pulled her leg out of the wheelchair, resulting in a significant injury and bleeding on her lower leg. Subsequently, a family member arrived and transported her to the emergency room, where she received a total of 23 stitches for the lower leg injury.

During an interview, a family member reported she visited the resident on that day. She mentioned the resident was not supposed to transfer herself and should have waited for assistance. The resident's leg got caught in the wheelchair, resulting in a cut. The family member confirmed it was an isolated incident, pointing out that the facility had another incident upstairs and failed to respond promptly. Despite this, she expressed satisfaction with the care the resident received and had no additional concerns.

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: No. The resident was unable to reach.
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
	34320	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CITY SENIOR LIVING	1520 17TH STREET NW FARIBAULT, MN 55021

(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 November 13, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL343206304M/HL343201961C. No correction orders are issued.	0 000		