Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL34401001M
Compliance #: HL34401002C

Date Concluded: April 30, 2021

Name, Address, and County of Licensee Investigated:
Milestone Senior Living
2500 14th Street NE
Faribault, MN 55021
Rice County

Facility Type: Home Care Provider

Investigator's Name:
Laura duCharme, RN, Special Investigator

Finding: Substantiated, individual responsibility

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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) neglected the client when the AP failed to transfer the client in a safe manner and according to facility policy, resulting in the client experiencing a fall with fracture.

Investigative Findings and Conclusion:
Neglect of care was substantiated. The AP, a unlicensed staff member, was responsible for the maltreatment. The AP did not use a gait belt to assist and support the client while toileting. The client subsequently fell in the bathroom and fractured her right ankle.

The investigation included interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigation included a review of the client's medical records, facility policies and procedures, and staff personnel records.

The client's diagnoses included but was not limited to monoclonal gammopathy (abnormal proteins or antibodies in the blood), disorder of the parathyroid gland, osteoarthritis, spinal stenosis, and abnormalities of gait and mobility. The client receives staff assistance with showers, personal hygiene, medication administration, and mobility.

Review of the client's care plan indicated the client had a history of falls and required one staff member for assistance with transfers with the use of a gait belt.

Review of client documentation indicated one evening the AP assisted the client to the bathroom. Upon getting off the toilet, the client hung onto the wall safety bar, lost her grip, and fell to the floor. The AP and another staff person assisted the client off the floor. The client developed pain in her right ankle following the fall and requested to go to the emergency room the following morning.

Review of the client's emergency room notes indicated the client received a closed fracture of the proximal right fibula (right ankle area). The client stayed overnight in the hospital for pain control and was discharged with orders for an orthopedic support device, activity restrictions, and pain medication.

Review of the facility investigation notes indicated the AP did not use a gait belt to transfer the client as care planned. It also indicated the AP did not assist the client off the floor according to facility policy.

Review of the AP's employment record indicated she had been employed for approximately two months prior to the incident and received training on the use of gait belts and safe client transfers upon hire. The AP signed the nurse delegation form indicating she had received appropriate education, demonstrated competency, and accepted accountability for performing the task per facility policy. The AP did not have any previous corrective action or incidents in her file.

During an interview, the AP stated she was assisting the client during the fall and was not using a gait belt during the transfer. She further stated she had read the client's care plan and signed it but does not remember reading anything about having to use a gait belt with the client. She stated she received re-education following the incident.

During an interview, a staff member stated he assisted the AP following the client's fall. The staff member stated the client was not wearing a gait belt at the time of the fall but should have been. The staff member stated a gait belt was used to assist the client off the floor. The staff member confirmed he received re-education after the incident.

In conclusion, neglect of care was substantiated against the AP.

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:

(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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

Action taken by facility:
The facility re-trained the AP and all staff on proper transfer techniques, fall prevention, walking with clients, and post-fall protocol.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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
Rice County Attorney
Faribault City Attorney
Faribault City Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34401	A. BUILDING: _____ B. WING _____	C 02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING	2500 14TH STREET NE 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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an 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: On February 24, 2021, the Minnesota Department of Health initiated an investigation of complaint HL34401001M/HL34401002C. At the time of the investigation, there were #36 clients receiving services under the comprehensive license. The following correction order is issued for HL34401001M/HL34401002C, tag identification 0325.	0 000		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable	0 325		

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0 325	Continued From page 1 Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of three clients (C1) reviewed were free from maltreatment. C1 was neglected. Findings include: On April 30, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person was responsible for the maltreatment in connection with an incident that occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report for details.	