Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL36601641M
Compliance #: HL366003178C

Date Concluded:

Name, Address, and County of Licensee Investigated:
Suite Living Senior Care of Brooklyn Park
8500 Regent Avenue North
Brooklyn Park, MN
Hennepin County

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

Evaluator's Name:
Katie Germann, RN Special Investigator
Maerin Renee, 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.

Initial Investigation Allegation(s):
The alleged perpetrators (AP1 and AP2) neglected a resident when they failed to ensure the resident was safe during a transfer while using a mechanical lift. The resident fell out of the mechanical lift, causing her to fall and sustain a brain bleed with scalp laceration requiring sutures, and two cervical neck fractures.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. AP1 and AP2 were responsible for the maltreatment. AP1 and AP2 assisted the resident with transferring from her bed to her wheelchair. AP1 and AP2 did not complete safety checks during the transfer which included ensuring the resident was secure in the mechanical lift sling. AP1 and AP2 did not place the straps of the mechanical lift sling beneath the resident's legs, which was required to keep the resident in place during a transfer. AP1 and AP2 did not notice they had forgotten to place

the straps beneath the resident's legs when they began to transfer her, and the resident fell out of the lift during the transfer.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident medical records, facility incident reports, hospital records, facility investigation, mechanical lift maintenance records, facility policies and procedures, and training records. Also, the investigators observed resident cares and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, heart failure, and chronic pain. The resident's service plan included assistance with activities of daily living, medication administration, bathing assistance, meals, housekeeping, and laundry. The resident's assessment indicated functional decline requiring her to use a mechanical lift for transfers.

Review of the facility internal investigation indicated AP1 and AP2 were transferring the resident to her wheelchair AP1 and AP2 crossed the leg straps of the lift sling over the resident's thighs instead of under, failing to secure the resident, and causing her to slip out of the sling while in the air. The resident hit her head on the side rail of the bed causing lacerations, a brain bleed, and two cervical neck fractures.

During an interview, a nurse stated AP1 and AP2 were experienced in using the mechanical lift. The nurse stated she had trained AP1 and AP2 in the use of mechanical lifts and had observed and supervised their return demonstrations herself.

During an interview, AP1 reported the resident wanted to be transferred from her bed to her wheelchair. AP1 had a disagreement with AP2 about which mobility aid to use during the transfer. AP2 told AP1 she did not know how to use the mechanical lift and wanted to use a strap-style stander, instead. AP1 informed AP2 the resident's care plan required using the mechanical lift, and AP1 offered to teach AP2 how to use the lift. AP1 stated when they were assisting the resident into the sling required for the lift, they took the straps for the lift and crossed them over the resident, instead of beneath the resident's legs as required to secure her into place. Neither AP1 nor AP2 noticed the incorrect placement of the straps and began to transfer the resident. While the resident was in the air, she said she felt that she was crooked. AP2 attempted to straighten the resident while the resident was in the air. AP1 pushed the lift back over to the resident's bed so they could adjust her, but the resident fell out of the sling, hitting her head against the bed and the floor.

When interviewed, AP2 stated staff was running behind when trying to get people out of bed for the morning. AP1 strapped the resident in the sling incorrectly, and AP2 did not notice until the resident had fallen out of the sling. AP2 admitted she normally double-checks to ensure the straps are correctly applied, but she was unfamiliar with this type of sling. AP2 denied she had been trained to use this type of mechanical lift.

Review of mechanical lift maintenance records indicated the resident's lift was free of defects or breakage. Review of staff training files indicated AP1 and AP2 successfully completed mechanical lift competency training.

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.

Vulnerable Adult interviewed: No, unable to contact resident.
Family/Responsible Party interviewed: No, family notified of investigation.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed re-education on safe use of mechanical lifts for all staff.

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.

You may also call 651-201-4200 to receive a copy via mail or email

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	C 11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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 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: #HL366003177C, #HL366003178C/#HL366001641M On November 1, 2022, 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 22 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL366003178C/#HL366001641M, tag identification 2360.	0 000	The Minnesota Department of Health documents 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 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: Based on observations, interviews, and document review, the facility failed to ensure one of one residents (R1) reviewed was free from maltreatment. R1 was neglected. Findings include: On November 1, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that two individual staff persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	