

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL395644181M
Compliance #: HL395644697C

Date Concluded: September 17, 2024

Name, Address, and County of Licensee

Investigated:

Well Care Health Services
3600 73rd Ave
Brooklyn Park MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier
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 facility neglected the resident when the facility did not provide assistance and she fell causing a fractured shoulder and hip.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility had provided and educated the resident a call button for assistance, which the resident wore around her neck. However, on this occasion the resident did not use the call button while retrieving something from the floor resulting in her fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's legal guardian. The investigation included review of facility records, resident records, medical records and policies. Also, the investigator observed staff interactions with other staff, residents, and visitors. The investigator also observed the resident's room and belongings placed in the room.

The resident resided in an assisted living facility. The resident's diagnoses included fibromyalgia, insomnia, and chronic pain. The resident's service plan included assistance with medications, transferring, dressing, bathing and toileting. The resident's assessment indicated the resident had a history of falls, was often impulsive with behaviors and did not always use her call button when needing assistance with transferring.

The resident's progress notes indicated one day the resident was sitting on the side of her bed, when she attempted to stand and reach for her coffee on the bedside table. The table slid away from the resident faster than she could move and she fell.

The same documents indicated a staff member came immediately and found the resident on the floor, in pain. The staff member attempted to comfort the resident, then called the nurse to ask for direction. The nurse called 911 and the resident was taken to the hospital and found to have a fractured shoulder and hip.

During an interview, the resident stated she had her call button but did not use it because she thought she would be fine. The resident also stated the staff acted quickly.

During an interview, the nurse stated that the resident has been educated on the use of the call button but does not always use it when she should. The nurse also stated the facility has fall mats around the resident's bed, but the resident does not like them, and she often pushes them out of the area.

During an interview, the unlicensed care giver stated the resident requires assistance but sometimes does not use the call button. The resident also moves the fall mats away from her bed sometimes.

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:

The facility had a call button for the resident and implemented fall mats. After the fall, the facility took quick action to get the resident care.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39564	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/04/2024
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NAME OF PROVIDER OR SUPPLIER WELL CARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 73RD AVENUE BROOKLYN PARK, MN 55429
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(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	<p>Initial Comments</p> <p>On September 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL395644697C/#HL395644181M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____