Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H51824443M, and #H51824425M

Date Concluded: August 30, 2023

Name, Address, and County of Licensee Investigated:
The Villa at St. Louis Park
7500 West 22nd Street
St. Lois Park, Mn 55426
Hennepin County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, 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):
Allegation #1: The alleged perpetrator (AP) abused a resident when AP-1 repeatedly demanded the resident to roll a specific direction the resident verbalized they were being unable to, and then forced the resident to do what AP-1 directed which caused the AP to fall out of bed. The resident was transferred to the emergency department for evaluation of his injuries.

Allegation #2: AP-2 and AP-3 neglected the resident when they failed to safely operate a full body mechanical Hoyer lift. The AP's turned the lift while the legs were closed, then pulled on the resident's sling while the resident was suspended in the air which caused the lift to tip over, as a result, the resident fell and sustained a vertebral fracture.

Investigative Findings and Conclusion:
Allegation #1: The Minnesota Department of Health determined abuse was not substantiated. AP-1 followed the residents plan of care at the time the incident occurred. A facility incident report indicated the resident's fall was intercepted by staff, indicating the resident did not fall

out of bed. The resident reported to emergency medical staff he rolled in a way he did not feel comfortable but did not verbalize being forced or abused by AP-1. AP-1 denied the allegation of abuse or forcing the resident to do anything.

Allegation #2: The Minnesota Department of Health determined neglect was not substantiated. A facility investigation identified inappropriate use of the lift by staff. However, AP-2 was not competency trained to safely operate the mechanical full body Hoyer lift at the time of the incident, and failed to ensure the legs of the lift remained open which made the lift unstable and difficult to turn. AP-3 did not notice the lift legs were closed and pulled on the resident's sling to assist with turning the lift, the lift tipped over, and the resident sustained an injury. A previous federal survey issued correction orders to the facility for failure to ensure safety when the mechanical lift was not used in accordance with the manufacturer's instructions resulting in the resident's fall and injury.

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 review of previous survey documentation, resident records, facility investigation, resident assessment, care plan, progress notes, incident reports, and outside medical records and radiology reports following both incidents.

The resident resided in a nursing home with diagnoses including morbid obesity, and lymphedema.

The resident's assessment and care plan indicated he was cognitively intact and required a sit to stand mechanical lift for transfers and utilized a full body Hoyer lift to obtain weights as needed. The assessment indicated R1 utilized bilateral mobility assist grab bars to reposition in bed. At the time of allegation #1 the assessment indicated the resident required assistance from one staff with bed mobility and identified no mobility limitations with rolling side to side.

The facility incident report indicated the resident had an intercepted fall out of bed. At the time of the incident AP-1 followed the resident's care plan to use one assist with bed mobility.

An outside medical record indicated the resident reported AP-1 came in to help him get cleaned up and had him roll in a way that he wasn't very comfortable with, and he ended up falling off the bed, catching the upper half of his body on the bed. The outside medical record did not indicate the resident reported being abused or forced to do something by AP-1.

Another facility incident report identified inappropriate lift use by staff as the cause of a resident fall. The report indicated AP-2 and AP-3 turned the lift with the bariatric resident suspended in the air with the legs together instead of extended out for stability which caused the lift to tip over.

When interviewed facility leadership who completed the investigations indicated in allegation #1 the resident had no concerns or complaints of abuse or being forced to roll by AP-1 at the time of the incident, and indicated the residents fall was intercepted by staff and the resident did not fall on the floor. Leadership staff stated for allegation #2, AP-2 had not completed competency to use the Hoyer lift at the time of the incident, and both staff were retrained after the incident occurred. Leadership staff stated after the incident both staff reenacted the event and AP-2 (who was not trained) operated the lift, and AP-3 assisted with the transfer. AP-2 lifted the resident from his chair and then pulled the lift back and closed the legs of the lift to turn it toward the bed. Both staff indicated the lift would not turn, and AP-3 had not noticed the lift legs were closed. AP-3 then pulled on the straps of the residents sling behind the resident to help turn the lift, the lift tipped, and the resident fell out of the lift.

When interviewed AP-1 denied the allegation of abuse.

When interviewed AP-2 stated at the time of the incident he was still being trained on using the Hoyer lift.

When interviewed AP-3 stated she did not notice AP-2 had the legs of the Hoyer lift closed when they were attempting to transfer the resident.

When interviewed the resident's family member indicated she did not recall the resident saying he was forced to do anything, and the resident fell from the lift due to the legs of the lift being closed during a transfer.

In conclusion, the Minnesota Department of Health determined abuse and neglect were 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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: Yes.

Action taken by facility:
The facility updated the residents care plan for two staff assistance with bed mobility after the incident occurred.
The facility trained/retrained staff on safe transfers using a full body mechanical Hoyer lift, suspended staff pending investigation, removed the lifts from service and inspected them for proper functioning, updated the competency skills check list to include specifically keeping the legs of the lift open.

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
	00278	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST LOUIS PARK LLC	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H51824443M, H51824425M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00278	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST LOUIS PARK LLC	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

(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
2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	