Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52986605M
Compliance #: H52981882C

Date Concluded: March 4, 2024

Name, Address, and County of Licensee Investigated:
The Estates at Twin Rivers
305 Fremont Street
Anoka, MN 55303
Anoka County

Facility Type: Nursing Home

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Inconclusive
Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP1), an unlicensed staff, neglected the resident when the AP failed to safely transfer the resident with a mechanical sit-to-stand lift. The resident fell during the transfer and suffered injury to a recent surgical wound that required further corrective surgery.

The alleged perpetrator (AP2), a facility licensed staff, neglected the resident when the AP failed to ensure the resident received appropriate care following a fall from a mechanical sit-to-stand lift. AP2 did not provide care for the resident's injuries or report the resident's injuries to other licensed staff, resulting in a delay in treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. AP1 was transferring the resident using a mechanical sit-to-stand lift. The resident slipped out of the sling and landed on a recent surgical incision following a left below-the-knee amputation (L

BKA). The residents medical record failed to instruct staff on the size of sling to use, and the facility did not know what sling was being used at the time of the residents fall. It could not be determined what contributed to the residents fall.

The Minnesota Department of Health determined neglect was substantiated. AP2 was responsible for the maltreatment. After the resident fell from the sit-to-stand lift and landed on the recent surgical incision of the below the knee amputation [stump], AP2 was called to the resident's room. AP2 failed to assess the resident's injury's, failed to provide any care to the residents' injury, and failed to report the resident's injury to oncoming licensed staff. The following morning, AP2 wrapped the residents bleeding stump in a pillowcase and again, failed to assess and to report the resident's injuries. Shortly after another licensed staff noticed the residents bleeding stump and called 911. The resident required surgery for an above-the-knee amputation (AKA) due to the extensive damage to the surrounding tissue.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed the residents medical, employee files, facility policies and procedures, federal investigation documents, and the facility's internal investigation.

The resident resided in a skilled nursing facility with diagnoses including hemiplegia and left above-the-knee amputation. The resident was full weight-bearing on the right leg and required physical assistance of one staff for transfers using a mechanical sit-to-stand lift.

The residents progress notes indicated one evening around bedtime, the resident was being transferred to her wheelchair using a mechanical sit-to-stand lift and during the transfer the resident slid to the floor. AP2 documented the resident had no injuries.

A progress note written the following morning by a licensed staff indicated the resident was observed in the wheelchair, with a pillowcase wrapped over the bloody sock on the L BKA. The nurse removed the dressings and pillowcase from the resident's BKA which were all soaked in blood. The nurse called 911 to transport the resident to the hospital. The progress note indicated the resident told the nurse she fell the previous night but AP2 did not look at her injury after the fall.

The facility internal investigation indicated the resident stated AP1 was going to transfer her to the bed using the mechanical sit-to-stand lift, but the bed was too high. The resident asked to be put in her wheelchair instead and AP1 pushed the resident toward the wheelchair. When the resident was about two inches from the wheelchair she slipped out of the sit-to-stand lift and hit the stump of the L BKA incision on the floor. The resident was unsure how she fell but after the fall there was a lot of blood. The resident stated AP2 did not do anything for the injury and the resident did not talk to the night nurse about the fall. The resident stated her legs were covered with blankets so the night nurse would not have seen the injury.

The investigation indicated AP1 stated she transferred the resident the same as she always had and was unsure how the resident fell out of the mechanical sit-to-stand lift. AP1 transferred the resident to her wheelchair and the resident stated she was slipping, and the resident asked to slide to the floor, and AP1 stated she did not drop the resident. AP1 stated, she requested assistance from other staff to get the resident back into bed. AP1 stated there was a puddle of blood on the floor and the resident's stump bandage was bloody, however, the resident did not complain of pain or discomfort.

The investigation indicated after the resident fell, AP2 stated she cleaned up blood from the resident's floor and the resident's stump was bleeding. AP2 stated she tried to look at the resident's injury, but the resident would not let her look at it. AP2 told the night nurse, "to deal with it," and left, as it was the end of her shift. In the same interview AP2 stated she documented the resident had no injuries and did not notify the family or the resident's provider, because she would have needed information about the wound, and she did not know anything about it. Investigation documents indicated the night nurse stated AP2 reported to her the resident had fallen out of her sit-to-stand lift, there were no injuries, and vital signs were fine. The night nurse stated no one informed her that blood had needed to be cleaned off the floor. The following morning staff noticed the resident's stump bandage was covered in blood. Staff notified AP2, who was working the day shift. AP2 placed a pillowcase around the resident's stump and told the resident the doctor was rounding that morning and would look at the residents bleeding surgical incision. Staff notified another licensed nurse about the resident's bloody bandages. The morning nurse removed the bandages and observed the resident's wound had completely opened. Staff called 911 to transport the resident to the hospital.

The resident's hospital record indicated the resident was diagnosed with stump breakdown after her fall and a suspected displaced patellar (knee) fracture. The resident's stump was inspected, and it was determined there was no way to salvage the L BKA, due to the short length of tibia remaining below the knee as well as poor quality/viability of the remaining tissues. The damaged stump was revised to an above-the-knee amputation (AKA).

Review of AP2's written warning indicated AP2 did not assess the resident's stump and falsely reported there was no injury on the incident report. AP2 was aware of the fall, cleaned up blood from the floor after the fall, and did not follow facility policies regarding falls. AP2 failed to utilize sound nursing judgement and critical thinking, which resulted in a delay of diagnosis and care for the resident.

When interviewed, an administrator stated the resident used a sit-to-stand lift for transfers but was otherwise independent. Staff reported the resident had fallen the night before and AP2 reported there were no injuries. The resident had just gotten her stitches from the L BKA removed that morning, so it was a newly healed incision. AP1 stated she transferred the resident with the sit-to-stand lift without incident. It was when she was helping the resident into bed that the resident slipped out of the sling. AP1 stated she did not know what happened, as she used the sit-to-stand lift as she normally did. The resident told the administrator AP1 did nothing wrong, and that she just got tired or weak. The administrator stated the resident fell

around shift change, so both AP2 and the night nurse thought the other was completing an assessment of the resident's stump. The administrator stated the sling size for the resident was not documented on the resident's care plan at that time, but it was documented on the guide unlicensed personnel (ULP) used to provide cares for each resident. However, the facility was unable to provide documentation that directed staff on the size sling to use for the resident.

When interviewed, AP1 stated she followed the resident's care plan when she completed the transfers that evening. AP1 said she could not remember the details of the care plan or the sling that she used with the sit-to-stand lift, but she did inform the nurse after the resident fell.

When interviewed, AP2 stated she helped the resident off the floor after her fall, using a mechanical lift, but the resident would not let her assess her stump. AP2 told the resident it was already past the time that her shift ended. AP2 stated she let the night nurse "deal with" cares and left. AP2 denied there was any injury to the resident, although she noted a small amount of bleeding from her knee.

When interviewed, the night nurse stated the resident used a sit-to-stand lift transfer. The nurse stated AP2 reported to her the resident had no injuries after the fall out of the lift. The night nurse administered pain medication to the resident later that night, and the resident requested to use the commode. An aide assisted the resident to the commode and informed the night nurse that there was a little bit of blood on the resident's stump. The night nurse did not follow up.

When interviewed, the resident stated her staples were removed from her L BKA surgery the day she fell. The resident state when she fell, she had just been transferred to the bathroom without incident. It was when AP1 attempted to transfer her to the bed that the resident felt the bed was too high and asked to be placed in her wheelchair. Before the resident reached the wheelchair the resident slipped out of the sit-to-stand lift sling. The resident stated after she fell, staff came in to help AP1 get her off the floor and clean her up. AP2 put a pillowcase around the residents bleeding stump but didn't look at the injury.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: Yes.
Family/Responsible Party interviewed: N/A
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and completed staff re-training in regard to fall protocols and policies.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. 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
Anoka County Attorney
Anoka City Attorney
Anoka Police Department
The Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	305 FREMONT STREET ANOKA, MN 55303

(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 #H52986605M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000		

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2 000	Continued From page 1 are issued for #H52986605M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850	No plan of correction is required for this tag.	