Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53327927M
Compliance #: H53324641C

Date Concluded: February 7, 2024

Name, Address, and County of Licensee Investigated:
The Estates at Excelsior LLC
515 Division Street
Excelsior, MN 55331
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Brooke Anderson, 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):
The alleged perpetrator (AP), an agency staff, neglected a resident when the AP failed to transfer the resident according to the resident's care plan resulting in injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident's plan of care was not followed, the error was an isolated incident. The resident was evaluated at the hospital and returned to baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident's medical record, facility investigation documentation, and previous related federal survey documentation.

The resident resided in a nursing home. The resident's diagnoses included physical debility, morbid obesity, and chronic pain. The resident's assessment indicated the resident was

cognitively intact. The resident's care plan indicated two staff and the use of a full body mechanical lift were required for transfers.

The facility incident report indicated the AP assisted the resident with morning cares and during a transfer with the mechanical lift, the lift tipped. Facility nursing staff immediately assessed the resident, and the resident was sent to the emergency room for further evaluation.

Hospital records indicated there was no evidence of serious injury and the resident was transferred back to the facility. Upon the resident's return to the facility, nursing staff implemented additional interventions to monitor the resident's condition and physical and occupational therapy services were initiated.

The facility completed an internal investigation into the incident. Internal investigation documentation indicated the AP requested assistance prior to the transfer of the resident, but staff refused to assist with the transfer. Following the incident, nursing staff were re-educated on the use of mechanical lifts and importance of following the care plan.

During an interview, the AP stated she was an agency staff member and had only worked at the facility one other time prior to the incident. The AP recalled the morning of the incident she got up all the residents she could independently and then waited for help with the residents who required the assistance of two staff. The AP approached facility staff multiple times for assistance, but they told her they had their own residents to get up. The AP acknowledged the resident's care plan directed for two staff and the mechanical lift for transfers, but the resident had been waiting an hour, so the AP transferred her independently due to staff's refusal to assist her with cares.

During interviews, facility administrative staff indicated all resident care plans were reviewed and nursing staff were re-educated following the incident.

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: No. Attempts to interview were unsuccessful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP did not return to work at the facility. The facility completed a comprehensive review of all resident transfer/mobility statuses and interviewed residents and additional nursing staff. Nursing staff education and mechanical lift competencies were completed, and mechanical lift transfer audits were implemented.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, 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.

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

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.

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
	00988	A. BUILDING: _____ B. WING _____	C 12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

(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 #H53327927M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000	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.	

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