Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54932582M **Date Concluded:** January 4, 2023

Name, Address, and County of Licensee Investigated:
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343
Hennepin County

Facility Type: Nursing Home **Evaluator's Name:** Jill Hagen, RN, Special Investigator

Finding: Not Substantiated

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 perpetrator (AP), facility staff, neglected a resident when the AP failed to follow the resident's care planned and assessed needs. The AP independently transferred the resident with a mechanical sling lift instead of with two staff and used a large instead of a medium sized sling. The resident fell out of the sling resulting in a laceration (cut) on her head, and fractured her clavicle (shoulder bone).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP failed to use two people and the correct size sling for the mechanical lift for the resident, the error was an isolated incident. The resident sustained injury, received immobilization for a fractured clavicle, and was expected to return to the resident's baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the resident medical record, policies and procedures, and a review of the on-site federal complaint investigation documentation.

The resident resided in a skilled nursing facility. The resident's diagnoses included Alzheimer's type dementia, muscle weakness, and arthritis. The resident's care plan directed staff to use two staff and a mechanical sling lift for transfers with a medium sized sling.

The facility investigation indicated one mid-morning the AP transferred the resident from the wheelchair using the mechanical sling lift without a second staff as care planned. In addition, the AP used the large sling instead of a medium sized sling according to the resident's assessment. When the AP moved the lift, the wheel on the bottom of the lift caught on a doorframe. The AP shifted the lift and the resident fell out the right side of the sling between the leg and shoulder straps.

The AP immediately contacted licensed staff for assistance. Licensed staff applied ice to an approximate ½ inch cut to the right side of the resident's head. Licensed staff arranged for the resident to be evaluated at a local hospital for complaints of right shoulder, back, and neck pain. The resident required hospitalization for monitoring and treatment of a right clavicle fracture.

During interview, the AP stated following breakfast the resident "screamed" and "demanded" the AP transfer her back to bed from the wheelchair. The AP stated his co-worker was on break and no other staff were available to help with the lift. The resident continued to scream and demand the AP assist her to lay down in bed. The AP located a sling already in the residents room and attached the sling to the mechanical lift. The AP stated when moving the lift, the wheels of the lift hit the side of the bathroom wall which shifted the resident's weight and she fell out the side of the sling to the floor. The AP stated he received training to use two staff for a mechanical sling lift and reference the resident's care plan for the correct sling size.

During an interview, management stated they were immediately called to the resident's room following the fall from the lift. Following an assessment, management arranged for the resident to be transported to a local hospital for an evaluation. Management said they immediately removed the AP from resident care pending their investigation into the incident and pulled the lift from resident use for a maintenance inspection. When observed by management, the straps on the sling were appropriately attached to the lift. Management stated the AP received training prior to the incident including using two staff for mechanical sling lifts and the appropriate assessed sling size for each resident.

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.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, transferred to another facility.
Family/Responsible Party interviewed: Attempted.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Management provided training to all staff including the AP regarding following every resident’s plan of care including two staff for all mechanical sling lifts and checking for the correct sling size. Management pulled all lifts and slings for inspection and safety of the equipment. Management observed staff and the AP provide return demonstrations of the use of the lift. Management began audits of ongoing staff compliance. The AP returned to work following a three-day suspension.

Action taken by the Minnesota Department of Health:

The facility was issued a federal deficiency for noncompliance with licensing requirements. For a copy of the Statement of Deficiencies, please call 651-201-4200.

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
	00727	A. BUILDING: _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(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 #H54932582M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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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		