Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204273426M
Compliance #: HL204273627C

Date Concluded: July 15, 2024

Name, Address, and County of Licensee Investigated:
Parkshore Silvercrest Properties
3663 Park Center Boulevard
St. Louis Park, MN 55416
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Brandon Martfeld, RN BSN
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), a facility staff member, neglected the resident when the AP did not follow the resident's plan of care, which resulted in the resident falling and fracturing the resident's hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP followed the resident's plan of care and facility policies and procedures at the time of the fall.

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 the resident records, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility.

The resident resided in an assisted living facility. The resident's diagnoses included macular degeneration (blurred or reduced vision) and idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause cannot be determined). The resident's service plan included staff assistance/reminders to use the bathroom throughout the day and night. The resident required supervision from staff to transfer and walk and used a walker to ambulate. The resident was able to make her needs known to staff but required assistance with decision making. The resident was at risk for falling.

The facility's incident report indicated in the early morning hours one day, the AP assisted the resident to the bathroom during a scheduled toileting time. The resident was walking to the bathroom when the resident's head fell forward and the resident's leg "gave out." The AP assisted the resident to the floor. The AP stated, "it was like she fell asleep while walking." The AP contacted the triage nurse and who directed the AP to give the resident Tylenol (for pain relief).

Transcripts of the phone call between the AP and the triage nurse indicated the resident walked to the bathroom and was lowered to the floor by the AP. The AP asked the resident "how bad is your pain", the resident said, "not too bad." The triage nurse instructed the AP to get the resident off the floor and to give Tylenol for the pain. The AP gave the resident Tylenol and assisted her back into bed. At that time, the resident's blood pressure was slightly elevated.

Approximately, one hour after the fall and as directed by the triage nurse, the AP checked on the resident and the resident's blood pressure. The resident told the AP she was fine and the resident's blood pressure had improved following the fall. Approximately four hours later, the resident complained of increased right hip pain and arrangements were made to evaluate the resident at a hospital.

Hospital Records indicated the resident had a right femur fracture, diagnosed as pathologic (indicative of or caused by disease) fracture due to osteoporosis (weakened and brittle bones.)

During an interview, the AP stated the resident walked to the bathroom, as the resident entered the bathroom, the resident started to go down. The AP stated one of the resident's legs was straight and the other leg was crossed underneath when the resident was lowered to the floor onto her back. The AP called another co-worker for help and then called the triage nurse. The nurse stated not to move the resident and ask if the resident had any pain. The resident's blood pressure was checked, and the resident was assisted back into bed. The AP stated the resident was checked on every two hours throughout the early morning, until she had to switch floors for another shift.

During an interview, nursing leadership stated the AP assisted the resident to the bathroom during a scheduled service. The AP lowered the resident to the floor when the resident's legs gave out. The AP called the on-call triage nurse. The resident had pain but was alert and wanted to go back to bed. The AP assisted the resident with getting Tylenol for pain. That morning, the

resident’s family member came into the facility, and at that time, it was decided that the resident be sent to the hospital.

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: No. Resided at an unknown facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
After the resident fell, the AP notified the triage nurse, checked the resident’s vital signs and gave Tylenol for pain.

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
	20427	A. BUILDING: _____ B. WING _____	C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

(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	Initial Comments On June 17, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL204273426M/#HL204273627C. No correction orders are issued.	0 000		