



Minnesota Department of Health

Office of Health Facility Complaints Investigative Report PUBLIC

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| Facility Name: Arbor Lakes Senior Living | | | Report Number: HL27690004 | Date of Visit: June 26, 2017 |
| Facility Address: 12001 80th Avenue North | | | Time of Visit: 9:30 a.m. to 4:45 p.m. | Date Concluded: December 6, 2017 |
| Facility City: Maple Grove | | | Investigator's Name and Title: William Nelson, RN, Special Investigator | |
| State: Minnesota | ZIP: 55369 | County: Hennepin | | |

☒ Home Care Provider/Assisted Living

Allegation(s):

It is alleged that a client was neglected by staff when the AP refused to assist client with toileting resulting in a fall when the client attempted toilet herself/himself. The AP refused to help client to the toilet at 1:48 a.m. so the client soiled herself/himself and the bed. The client attempted to get out of the bed at 3 - 3:30 a.m. and fell. The AP found the resident about 4:40 a.m. and reluctantly and roughly assisted the client back into the unclean bed. The client was transported to ED at shift change and found to have a fractured hip.

- ☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect is substantiated. The alleged perpetrator (AP) transferred the client back into bed after a fall in an inappropriate manner, did not check on the client after the fall, and did not report the fall to the nurse or other staff members.

The client's diagnoses included a wedge compression fracture of the fourth lumbar vertebrae, atrial fibrillation, diabetes type II, age-related osteoporosis, and chronic kidney disease, stage four (severe). The client received assistance with activities of daily living, including toileting, bathing, oral care, getting dressed, ambulation, and grooming. The staff also assisted the client with medications and laundry. The staff were to use a transfer belt when assisting the client with ambulation. The client's memory was intact.

At approximately 4:45 a.m. on the day of the incident, the AP found the client on the floor in the client's room. The AP documented that the client was sitting on the floor near the client's bed, but the client stated s/he had fallen while attempting to get to the bathroom and was not near the bed. The AP initially stated the AP would not assist the client in getting up, and told the client that the client got him/herself into the

situation and was on his/her own in getting out of the situation. The client repeated requests for assistance, and then the AP lifted the client under the client's arms, without using a transfer belt. The AP was unable to get the client into the bed on the first attempt, but on the second attempt, the AP placed the client's torso on the bed and then swung the client's leg onto the bed. The AP documented that the client reported no pain, however the client told other staff and family members that s/he had cried out in pain during the movements.

When the next shift came on duty, a direct care staff member entered the client's room. The client was normally sitting on the bed waiting for the morning staff to get the client up for the day, but the client was laying down. When the staff member approached the client, the client reported severe leg and hip pain. The client's bed was wet and the client did not have a shirt on. The staff member contacted the nurse, who came and assessed the client. The nurse found the client could not move the client's left leg and had significant pain. The client told the nurse that the client fell while walking back from the bathroom and pressed his/her pendant for assistance. The client stated the AP entered the room, cursed at the client, drug the client to the bed, and "threw" the client into bed. Staff contacted the family, and the family and nurse decided to transport the client to the hospital via ambulance. The client was admitted and was diagnosed with a femur fracture, and required surgical intervention.

Interviews with family indicated that the client told family members the client had pressed his/her call light to get help going to the bathroom, but no one came. The client decided to go to the bathroom without assistance, and fell near the client's closet on the way back from the bathroom. When the AP came to the client's room, the AP stated s/he did not want to clean the client and would not get the client up. After the client asked if the AP was refusing the help, the AP lifted the client under the client's arms, without a transfer belt, and dragged the client to the bed. The AP placed the client's torso on the bed and then swung the client's leg onto the bed. One family member also indicated the client reported the client's bed was wet and the AP refused to change the sheets, but placed another sheet on top of the wet area.

During an interview, the client stated s/he fell and could not get up, and the AP came in and would not help him/her at first. The client stated the AP dragged the client to the bed. The client stated s/he was wet and the AP would not help him/her change.

During interviews, members of management staff stated they reviewed the facility security cameras, and the footage supported the client's account of the incident. The AP only entered the client's room at three points during the shift, once prior to the incident for about eight minutes, at the reported time of the incident for less than two minutes, and after the incident for less than two minutes. The home care provider terminated the AP based on this incident.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse | <input checked="" type="checkbox"/> Neglect | <input type="checkbox"/> Financial Exploitation |
| <input checked="" type="checkbox"/> Substantiated | <input type="checkbox"/> Not Substantiated | <input type="checkbox"/> Inconclusive based on the following information: |

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The individual is responsible for the neglect. The alleged perpetrator (AP) was trained on how to correctly transfer the client, but did not follow those procedures. The home care provider had policies on when to contact the nurse, the AP was aware of the policy to contact the nurse prior to moving a client who fell, but chose not to do so. The home care provider had policies requiring the AP to report falls, and the AP did not report the fall to anyone.

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.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met

The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met

The requirements under State Statutes for Chapters 144 & 144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

Facility Name: Arbor Lakes Senior Living

Report Number: HL27690004

- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☐ Assessments
- ☒ Physician Orders
- ☒ Facility Incident Reports
- ☒ Service Plan

Other pertinent medical records:

- ☒ Hospital Records

Additional facility records:

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Call Light Audits
- ☒ Personnel Records/Background Check, etc.
- ☒ Facility In-service Records
- ☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: None

Were residents selected based on the allegation(s)? ☒ Yes ☐ No ☐ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

☐ Yes ☒ No ☐ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ☒ Yes ☐ No ☐ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

Interview with family: ☒ Yes ☐ No ☐ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

☒ Yes ☐ No ☐ N/A Specify: _____

Facility Name: Arbor Lakes Senior Living

Report Number: HL27690004

Did you interview additional residents? ☐ Yes ☒ No

Total number of resident interviews: One

Interview with staff: ☒ Yes ☐ No ☐ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ☒ Yes ☐ No

Total number of staff interviews: Four

Physician Interviewed: ☐ Yes ☒ No

Nurse Practitioner Interviewed: ☐ Yes ☒ No

Physician Assistant Interviewed: ☐ Yes ☒ No

Interview with Alleged Perpetrator(s): ☒ Yes ☐ No ☐ N/A Specify: _____

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

If unable to contact was subpoena issued: ☐ Yes, date subpoena was issued _____ ☐ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Facility Tour

Was any involved equipment inspected: ☐ Yes ☐ No ☒ N/A

Was equipment being operated in safe manner: ☐ Yes ☐ No ☒ N/A

Were photographs taken: ☐ Yes ☒ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Maple Grove Police Department

Hennepin County Attorney

Maple Grove City Attorney



Protecting, Maintaining and Improving the Health of All Minnesotans

February 20, 2018

Mrs. Kelly Myers, Administrator
Arbor Lakes Senior Living
12001 80th Avenue North
Maple Grove, MN 55369

RE: Complaint Number HL27690004

Dear Mrs. Myers :

On January 8, 2018 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on October 30, 2017. **At this time, these correction orders were found corrected.**

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Matthew Heffron'.

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H27690 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 10/30/2017 |
|---|--|--|--|

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR LAKES SENIOR LIVING

**12001 80TH AVENUE NORTH
MAPLE GROVE, MN 55369**

| (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 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>A complaint investigation was conducted to investigate complaint #HL27690004. The following correction orders are issued.</p> | 0 000 | <p>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.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of 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 evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p> | |
| 0 320 SS=D | <p>144A.44, Subd. 1(13) Treated With Respect</p> <p>Subdivision 1. Statement of rights. A person who receives home care services has these rights:</p> | 0 320 | | |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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| 0 320 | <p>Continued From page 1</p> <p>(13) the right to be treated with courtesy and respect, and to have the client's property treated with respect;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide courteous and respectful treatment for 1 of 1 clients (C1) when the client had a fall while walking back from the bathroom and the staff member initially refused to assist the client up from the floor and responded to the client's request in a disrespectful and rough manner.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>C1's service plan, dated 03/04/2017, identified medication management program, laundry services, assistance with morning cares, evening cares, toileting, and getting to and from meals. C1 required one to two staff to assist him when ambulating. C1 received hourly checks.</p> <p>C1's fall risk assessment, dated 03/04/2017, assessed C1 as a high risk for falls due to factors such as previous falls, toilet assist required, balance problems, use of a walker and wheelchair, and medications. A fall assessment</p> | 0 320 | | | |

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| 0 320 | <p>Continued From page 3</p> <p>severe pain in his left leg and could not move the leg at all. RN-A asked NA-B to call C1's family while she called the night Nursing Assistant to find out what went on. When the family arrived, RN-A went in and spoke with C1. C1 told RN-A that he got up to go to the bathroom and fell while walking back. C1 said he called for help and the night nursing assistant came in, but cursed at him and verbally abused him. C1 stated the night nursing assistant then drug him to the bed and "threw" him into the bed. C1 said it was not accurate that he was sitting by the bed when the night nursing assistant came into the room. RN-A stated that C1's memory was normally intact. The decision was made to call 911 and send C1 to the hospital.</p> <p>During an interview of Nursing Assistant (NA)-B on 6/26/ 2017 at 1:50 p.m., NA-B stated he worked the day shift, know C1 well, and had a good working relationship with C1. NA-B reported that the normal routine was that C1 would be sitting on the edge of the bed waiting for NA-B to come in and assist C1 in getting up. However, on the morning of the incident, C1 was still in bed when NA-B entered the room. NA-B said that C1 had no shirt on and the bed was wet around the middle. C1 had some covers on and was on his back, with his head turned left looking out the window. NA-B believed C1 had taken off his T-shirt because it was wet. NA-B went over and touched C1's left leg and C1 yelled out in pain. NA-B said the nurse told him to call the family right away and he tried, but there was no answer. He called a cell phone number and found out that they were on their way over. NA-B asked C1 what happened. C1 told NA-B that he had pushed the pendent because he had to go to the bathroom, and no one came, so C1 got up and went himself. In the course of doing so, C1 fell.</p> | 0 320 | | |

Minnesota Department of Health

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| 0 320 | <p>Continued From page 4</p> <p>The night aide came in and drug C1 to bed, put C1 in the bed, and did not return to check on C1. NA-B said that the nurse and family came in and talked, and decided to send C1 to the hospital by ambulance. NA-B reported that C1's memory was good, and that C1 ordinarily remembered the daily routine, and NA-B's name and schedule.</p> <p>During an interview of C1 on 7/5/2017 at 11:00 a.m., C1 was asked what happened and how his hip was broken. C1 stated that he was on the floor, the "guy wouldn't help" and that he had to demand help. C1 was in the hospital at the time of this interview.</p> <p>During an interview of Family Member (FM)-1 on 7/5/2017, FM-1 said that s/he was there the morning C1 was injured. C1 told FM-1 that he had to go to the bathroom, so he pushed the pendent call light. No one came, so C1 got up and went to the bathroom by himself, and while returning he fell down in front of the closet. When the night assistant came in and saw C1 on the floor, the night nursing assistant refused to help C1. The night nursing assistant then grabbed C1 and dragged C1 to his bed.</p> <p>During an interview of Family Member (FM)-2 on 7/10/2017, FM-2 said that s/he was present the morning that C1 was injured. FM-2 and FM-1 were driving to the facility when they received a call telling them that C1 was reporting severe pain in his left leg. When they arrived C1 was in a lot of pain with movement, and after talking with NA-B and RN-A they decided to send C1 into the hospital. FM-2 had written up notes on the day provided them. Review of these notes, dated 5/21/2017, indicated C1 reported to family that the night nursing assistant came in and saw C1 on the floor, used abusive language towards C1,</p> | 0 320 | | |

Minnesota Department of Health

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| 0 320 | <p>Continued From page 2</p> <p>was repeated on 3/30/2017 and the assessment rating remained at high risk for falling.</p> <p>An incident/accident report, dated 05/04/2017 at 4:40 a.m., indicated that C1 reported that he was walking from the bathroom, became tired, and decided to sit down on the floor and lean against the bed. The night nursing assistant reported finding C1 on the floor leaning against his bed. The incident report stated C1 denied falling and reported no pain. There were no witnesses. The night nursing assistant reportedly moved C1's limbs, and documented that C1 reported no pain. The night nursing assistant reported that he used a transfer belt to help C1 up.</p> <p>The video recording of the hallway was reviewed, and identified that the night nursing assistant entered C1's room at 1:49 a.m. and left at 1:57 a.m., entered at 4:20 a.m. and left at 4:21 a.m., and entered again at 5:12 a.m. and left C1's apartment at 5:13 a.m.</p> <p>C1 reported significant pain to the morning shift nursing assistant and he reported this to the registered nurse (RN). C1 was assessed by the RN, and after discussing the findings with the family, the decision was made to send C1 to the hospital for evaluation of his left leg due to severe pain with movement.</p> <p>During an interview of Registered Nurse RN-(A) on 6/26/2016 at 2:25 p.m., RN-A stated that NA-B called RN-A the morning of the incident and said C1 was in bed, was reporting that he had severe pain in his left hip and leg, and had stated he fell last night. RN-A asked NA-B if a fall had been reported, NA-B said nothing had been reported or written on the report board. RN-A went to C1's room and assessed C1. RN-A found C1 had</p> | 0 320 | | | |

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| 0 320 | Continued From page 5 stating he did not want to help clean C1. C1 said that the night nursing assistant said, "you got yourself into this, you get yourself out of it...you're on your own." C1 asked the night nursing assistant if he was refusing to help C1. C1 told family that the night nursing assistant did not clean C1's wet bed, but instead placed a square sheet over the wet sheets. He also did not change C1's clothes. The night nursing assistant lifted C1 by himself, without assistance, under C1's arms, and did not use a transfer belt. C1 stated that the night nursing assistant could not get him onto the bed on the first attempt. The night nursing assistant then put C1 on the floor next to the bed, again picked C1 up, put C1's torso on the bed, and then swung C1's legs onto the bed. All the while, C1 stated he was in significant pain and cried out in pain without any response from the night nursing assistant. During an interview of C1 on 9/1/2017, C1 was at his home, sitting at a table in a wheelchair. C1 was asked if he recalled what happened the night he fractured his hip. C1 said that he remembers falling down, by his closet and not being able to get up. The night person came in and would not help him at first, and when C1 asked him again and he drug C1 to his bed. C1 said he was wet and that the night person would not help change him. C1 stated "It was a very lonely night," because "the guy didn't want to help me at all." Time Period for Correction: Twenty one (21) days | 0 320 | | | |
| 0 325 SS=G | 144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: | 0 325 | | | |

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| NAME OF PROVIDER OR SUPPLIER ARBOR LAKES SENIOR LIVING | | STREET ADDRESS, CITY, STATE, ZIP CODE 12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369 | | |
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| 0 325 | <p>Continued From page 6</p> <p>(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 client (C1) was free from maltreatment (neglect) when C1 fell during the night and was initially left on the floor. The night staff person then roughly handled the client without calling for assistance or calling the on call registered nurse prior to moving the resident. The client was injured during the transfer from the site of the fall and while being placed back into the client's bed, and suffered a fractured hip. The client was left in the bed until the day shift came in and transferred the client to the hospital for surgery.</p> <p>This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>C1's service plan, dated 03/04/2017, identified medication management program, laundry services, assistance with morning cares, evening cares, toileting, and getting to and from meals. C1 required one to two staff to assist him when ambulating. C1 received hourly checks.</p> | 0 325 | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H27690 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 10/30/2017 |
| NAME OF PROVIDER OR SUPPLIER ARBOR LAKES SENIOR LIVING | | STREET ADDRESS, CITY, STATE, ZIP CODE 12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369 | | |
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| 0 325 | <p>Continued From page 7</p> <p>C1's fall risk assessment, dated 03/04/2017, assessed C1 as a high risk for falls due to factors such as previous falls, toilet assist required, balance problems, use of a walker and wheelchair, and medications. A fall assessment was repeated on 3/30/2017 and the assessment rating remained at high risk for falling.</p> <p>An incident/accident report, dated 05/04/2017 at 4:40 a.m., indicated that C1 reported that he was walking from the bathroom, became tired, and decided to sit down on the floor and lean against the bed. The night nursing assistant reported finding C1 on the floor leaning against his bed. The incident report stated C1 denied falling and reported no pain. There were no witnesses. The night nursing assistant reportedly moved C1's limbs, and documented that C1 reported no pain. The night nursing assistant reported that he used a transfer belt to help C1 up.</p> <p>The video recording of the hallway was reviewed, and identified that the night nursing assistant entered C1's room at 1:49 a.m. and left at 1:57 a.m., entered at 4:20 a.m. and left at 4:21 a.m., and entered again at 5:12 a.m. and left C1's apartment at 5:13 a.m.</p> <p>C1 reported significant pain to the morning shift nursing assistant and he reported this to the registered nurse (RN). C1 was assessed by the RN, and after discussing the findings with the family, the decision was made to send C1 to the hospital for evaluation of his left leg due to severe pain with movement.</p> <p>A progress note, dated 5/4/2017, was reviewed. The progress note, written by RN-A, indicated C1 reported severe pain in the left hip area and</p> | 0 325 | | |

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| 0 325 | <p>Continued From page 8</p> <p>reported he had a fall during the night. RN-A called the night nursing assistant, who stated he found C1 sitting on the floor next to his bed around 4:45 a.m. RN-A called the family at 9:45 a.m. to notify them C1 had a fall. The family Physician Assistant (PA) was also notified at around 9:45 a.m. Family arrived at about 10:00 a.m., and an ambulance was called at that time. The ambulance arrived at 10:15 a.m. and transported C1 to the hospital. The family called the home care provider and stated the hospital confirmed that there was a fracture of the femur bone.</p> <p>During an interview of Registered Nurse RN-(A) on 6/26/2016 at 2:25 p.m., RN-A stated that NA-B called RN-A the morning of the incident and said C1 was in bed, was reporting that he had severe pain in his left hip and leg, and had stated he fell last night. RN-A asked NA-B if a fall had been reported, NA-B said nothing had been reported or written on the report board. RN-A went to C1's room and assessed C1. RN-A found C1 had severe pain in his left leg and could not move the leg at all. RN-A asked NA-B to call C1's family while she called the night Nursing Assistant to find out what went on. When the family arrived, RN-A went in and spoke with C1. C1 told RN-A that he got up to go to the bathroom and fell while walking back. C1 said he called for help and the night nursing assistant came in, but cursed at him and verbally abused him. C1 stated the night nursing assistant then drug him to the bed and "threw" him into the bed. C1 said it was not accurate that he was sitting by the bed when the night nursing assistant came into the room. RN-A stated that C1's memory was normally intact. The decision was made to call 911 and send C1 to the hospital.</p> | 0 325 | | | |

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| 0 325 | <p>Continued From page 9</p> <p>During an interview of Nursing Assistant (NA)-B on 6/26/ 2017 at 1:50 p.m., NA-B stated he worked the day shift, know C1 well, and had a good working relationship with C1. NA-B reported that the normal routine was that C1 would be sitting on the edge of the bed waiting for NA-B to come in and assist C1 in getting up. However, on the morning of the incident, C1 was still in bed when NA-B entered the room. NA-B said that C1 had no shirt on and the bed was wet around the middle. C1 had some covers on and was on his back, with his head turned left looking out the window. NA-B believed C1 had taken off his T-shirt because it was wet. NA-B went over and touched C1's left leg and C1 yelled out in pain. NA-B said the nurse told him to call the family right away and he tried, but there was no answer. He called a cell phone number and found out that they were on their way over. NA-B asked C1 what happened. C1 told NA-B that he had pushed the pendent because he had to go to the bathroom, and no one came, so C1 got up and went himself. In the course of doing so, C1 fell. The night aide came in and drug C1 to bed, put C1 in the bed, and did not return to check on C1. NA-B said that the nurse and family came in and talked, and decided to send C1 to the hospital by ambulance. NA-B reported that C1's memory was good, and that C1 ordinarily remembered the daily routine, and NA-B's name and schedule.</p> <p>During an interview of C1 on 7/5/2017 at 11:00 a.m., C1 was asked what happened and how his hip was broken. C1 stated that he was on the floor, the "guy wouldn't help" and that he had to demand help. C1 was in the hospital at the time of this interview.</p> <p>During an interview of Family Member (FM)-1 on 7/5/2017, FM-1 said that s/he was there the</p> | 0 325 | | |

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR LAKES SENIOR LIVING

**12001 80TH AVENUE NORTH
MAPLE GROVE, MN 55369**

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| 0 325 | <p>Continued From page 10</p> <p>morning C1 was injured. C1 told FM-1 that he had to go to the bathroom, so he pushed the pendent call light. No one came, so C1 got up and went to the bathroom by himself, and while returning he fell down in front of the closet. When the night assistant came in and saw C1 on the floor, the night nursing assistant refused to help C1. The night nursing assistant then grabbed C1 and dragged C1 to his bed.</p> <p>During an interview of Family Member (FM)-2 on 7/10/2017, FM-2 said that s/he was present the morning that C1 was injured. FM-2 and FM-1 were driving to the facility when they received a call telling them that C1 was reporting severe pain in his left leg. When they arrived C1 was in a lot of pain with movement, and after talking with NA-B and RN-A they decided to send C1 into the hospital. FM-2 had written up notes on the day provided them. Review of these notes, dated 5/21/2017, indicated C1 reported to family that the night nursing assistant came in and saw C1 on the floor, used abusive language towards C1, stating he did not want to help clean C1. C1 said that the night nursing assistant said, "you got yourself into this, you get yourself out of it...you're on your own." C1 asked the night nursing assistant if he was refusing to help C1. C1 told family that the night nursing assistant did not clean C1's wet bed, but instead placed a square sheet over the wet sheets. He also did not change C1's clothes. The night nursing assistant lifted C1 by himself, without assistance, under C1's arms, and did not use a transfer belt. C1 stated that the night nursing assistant could not get him onto the bed on the first attempt. The night nursing assistant then put C1 on the floor next to the bed, again picked C1 up, put C1's torso on the bed, and then swung C1's legs onto the bed. All the while, C1 stated he was in</p> | 0 325 | | |

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| 0 325 | <p>Continued From page 11</p> <p>significant pain and cried out in pain without any response from the night nursing assistant.</p> <p>During an interview of C1 on 9/1/2017, C1 was at his home, sitting at a table in a wheelchair. C1 was asked if he recalled what happened the night he fractured his hip. C1 said that he remembers falling down, by his closet and not being able to get up. The night person came in and would not help him at first, and when C1 asked him again and he drug C1 to his bed. C1 said he was wet and that the night person would not help change him. C1 stated "It was a very lonely night," because "the guy didn't want to help me at all."</p> <p>Time Period for Correction: Twenty one (21) days</p> | 0 325 | | |



Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8303

December 12, 2017

Mrs. Kelly Myers, Administrator
Arbor Lakes Senior Living
12001 80th Avenue North
Maple Grove, MN 55369

RE: Complaint Number HL27690004

Dear Mrs. Myers:

A complaint investigation (#HL27690004) of the Home Care Provider named above was completed on October 30, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

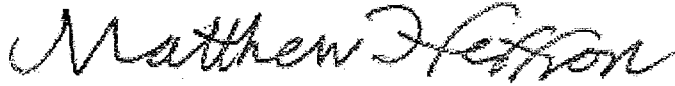
A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

Arbor Lakes Senior Living
December 12, 2017
Page 2

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Matthew Heffron". The signature is written in a cursive, flowing style.

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services