

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL279813146M  
**Compliance #:** HL279815147C

**Date Concluded:** January 18, 2023

**Name, Address, and County of Licensee**

**Investigated:**

Fridley Assisted Living  
6352 Central Avenue Northeast  
Fridley, MN 55432  
Anoka County

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

**Evaluator's Name:**

Katie Germann, RN, Special Investigator

**Finding: Substantiated, individual responsibility**

**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) neglected the resident when the AP independently transferred the resident using a mechanical standing lift. The resident fell out of the lift resulting in a fractured arm.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the resident's care plan which directed the resident required two staff assistance and a mechanical standing lift for all transfers. The AP transferred the resident using the standing lift without another staff. The resident fell out of the lift, hit her head, and sustained a left arm fracture.

The investigator conducted interviews with facility staff members, including administrative, nursing, and unlicensed staff. The investigation included review of medical records, service and care plans, incident reports, employee files, and facility policies and procedures related to falls,

training and competency, and vulnerable adults. In addition, the investigator observed resident cares and the facility mechanical standing lifts.

The resident resided in an assisted living facility with diagnoses including hemiplegia and hemiparesis of the left side. The resident's service plan included assistance with activities of daily living, shower assistance, medication administration and management, meals, housekeeping, and laundry. The resident required assistance of two staff and a standing mechanical lift for all transfers.

Review of medical records indicated the AP was assisting the resident with toileting and transferred the resident without a second staff to assist with the mechanical standing lift. The AP indicated the resident became weak during the transfer, fell out of the lift, and hit her head on the floor. The AP then called another facility staff member to assist with transferring the resident off the floor to her chair. The nurse assessed the resident at the time and did not observe any signs of injury. However, approximately two days following the fall, the resident reported pain in her left arm that was not improving with prescribed pain medication. The physician ordered an x-ray of the resident's left arm which indicated a fracture in the upper left arm. The resident was prescribed stronger pain medication and physical and occupational therapies.

A facility investigation indicated other staff who were working at the time of the incident did not recall the AP requesting assistance with transferring the resident.

When interviewed a facility nurse stated after the resident fell the AP admitted to transferring the resident using the mechanical standing lift without assistance from a second staff. The nurse indicated the AP told her she [AP] had not requested another staff to assist with transferring the resident. The nurse stated all staff are aware if any resident uses a mechanical standing lift two staff must provide assistance with the transfer.

When interviewed the AP stated she was aware the resident required two staff to provide assistance with transfers using the mechanical standing lift. The AP stated she asked for other staff assistance to transfer the resident, but no one responded they could assist. The AP stated after the resident became weak and fell out of the mechanical standing lift, the maintenance person assisted the AP with lifting the resident off the floor and into a chair.

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

**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:** No, resident is her own responsible party

**Alleged Perpetrator interviewed:** Yes

**Action taken by facility:**

The facility completed education on transfer safety with all staff. The AP is no longer employed at the facility.

**Action taken by the Minnesota Department of Health:**

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

Fridley City Attorney

Fridley Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>27981</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/20/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FRIDLEY ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6352 CENTRAL AVENUE FRIDLEY, MN 55432</b>
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(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
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0 000	<p><b>Initial Comments</b></p> <p>Initial comments *****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a 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>#HL279815147C/#HL279813146M</p> <p>On December 20, 2022 , the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 59 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL279815147C/#HL279813146M, tag identification 2360.</p>	0 000	<p>The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction.</p> <p>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction."</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.</p>	
02360	<p><b>144G.91 Subd. 8 Freedom from maltreatment</b></p> <p>Residents have the right to be free from physical,</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>FRIDLEY ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6352 CENTRAL AVENUE FRIDLEY, MN 55432</b>
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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 1 of 1 residents, R1, was free from maltreatment. The resident was neglected.</p> <p>Findings include:</p> <p>On December 20, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual was responsible for the maltreatment, in connection with incidents, which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.</p>	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	