DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294082340M
Compliance #: HL294081405C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee Investigated:
Mendota Heights White Pine
745 South Plaza Drive
Mendota Heights, MN 55120
Dakota 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):
Facility staff members, alleged perpetrators (AP #1 and AP #2) neglected the resident when the resident fell from a manual pump lift. The resident sustained bruises.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell from the manual pump lift, AP #1 and AP #2 followed the resident's care plan. In addition, the facility was aware the manual pump lift occasionally released the resident too quickly and arranged for the pump on the lift to be replaced, however the manual lift pump continued to have issues with lifting and releasing the resident. Prior to the incident, the facility was in the process of assisting the resident with obtaining an electric lift for transfers.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted both AP #1, AP # 2, and the resident. The investigation included review of the resident records, facility incident reports,

personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident in the facility and facility's lift equipment.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cerebral palsy and obesity. The resident's assessment indicated the resident was alert, oriented and required two staff members and a manual pump lift for transfers.

Progress notes indicted the day of the incident facility staff notified the on-call nurse to report the resident had an injury when the resident was transferred from the wheelchair to bed using the manual pump lift. The manual pump lift did not allow the staff to lower the resident slowly and lowered the resident to the bed too fast. The resident stated that the manual pump lift "drops" her. The resident stated following the incident, she had pain in the right lower leg, specifically below the knee. The progress notes also indicated; the resident had been evaluated at a hospital the same week prior to the incident for right leg pain.

During an interview, AP #1 stated on the day of the incident, AP #1 and AP #2 transferred the resident from her wheelchair into her bed using the manual pump lift. During the transfer the manual pump lift started to lower the resident before the resident was over the bed. AP #1 stated he pushed the resident onto the bed as the manual pump lift started to lower the resident.

During an interview, AP #2 stated the resident required two staff and a manual pump lift for transfers. AP #2 stated her, and AP #1 transferred the resident from her wheelchair into her bed. As they pushed the manual pump lift under the bed, the lift tipped, and the resident landed on the bed.

During an interview, a registered nurse stated the resident required two staff members for transfers. The resident used a manual pump sling lift for transfers and prior to the incident there were issues with the pump on the lift. When the pump was released, the lift lowered the resident quickly. The registered nurse stated a medical company came to look at the lift prior to the incident and replaced the pump. Because the lift continued to be an issue even with the new pump, the facility along with the resident's primary care provider arranged for the resident to get an electric sling lift. The day of the incident and prior to the delivery of the electric sling lift, the pump released the resident too quickly and the lift tipped. The arm of the lift hit the resident's leg, the resident sustained a bruise to her knee and leg.

During an interview, leadership stated after the fall, the resident sustained a bruise to her ankle. The resident had x-rays completed, which were negative for fractures. About two weeks following the incident, an electric sling lift was delivered for the resident and education on transfers were completed with the staff.

During an interview, the resident stated during a transfer the manual pump lift got caught on the bed and tipped sideways. The resident stated she landed on the bed, and the lift hit her in

the ankles. The resident stated she sustained a bruise to her ankle. The resident stated it was not the fault of the facility or staff.

In conclusion, the Minnesota Department of Health determined neglect 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. Resident was responsible for self.
Alleged Perpetrator interviewed: Yes. Both AP #1 and AP #2.

Action taken by facility:
The facility completed an internal investigation, obtained a new electric lift for the resident and all staff on transfers.

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
	29408	A. BUILDING: _____ B. WING _____	C 05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	**745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120**

(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 May 20, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL294082340M / HL294081405C #HL294081960M / HL294089742C #HL294081402M / HL294088961C No correction orders are issued.	0 000		