

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL295766103M  
**Compliance #:** HL295761487C

**Date Concluded:** September 14, 2023

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

### **Investigated:**

All Saints Senior Living  
1880 Independence Drive  
Shakopee, MN 55379  
Scott County

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

**Evaluator's Name:** Lissa Lin, RN  
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:**

The alleged perpetrator (AP) emotionally abused the resident when she yelled "damn it" after the resident fainted during a mechanical transfer and slipped in the lift.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was not substantiated. The AP used improper language one time when the resident fainted midway through a mechanical lift transfer from the bathroom using a standing mechanical lift. The AP then made sure the resident was safe and went to get help. In addition, neglect was not substantiated. Although, the AP transferred the resident without a second staff member using a mechanical lift, it was a one-time occurrence, the resident was provided medical treatment, returned to baseline health status, and the AP received retraining.

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 resident records, in room camera footage, policies and procedures and personnel records. Also, the investigator observed staff members using the standing mechanical lift to transfer residents and observed the resident receive hospice cares.

The resident resided in an assisted living facility. She lived on a unit, which housed residents needing more 1:1 cares and mechanical lift transfers. The resident's diagnoses included Parkinson's, diabetes, congestive heart failure, benign vertigo (dizziness) and weakness. The resident's service plan included assistance with toileting and transfers with a standing mechanical lift with two staff. The resident's assessment indicated she could make her needs known.

One day, the AP helped the resident transfer from the toilet using the standing mechanical lift. Room camera footage showed the AP backing the lift out of the bathroom by herself. The resident stood facing the AP and grasping the two standing mechanical lift handles which were positioned overhead and slightly behind her head. A safety sling encircled the resident's chest. About midway through the bathroom doorway, the resident went limp; her head dropped forward, and she let go of the lift handlebars but remained upright. The AP yelled hang on and the resident's name. The AP yelled, hang on to the bar "damn it!" The AP checked the resident's hands and said her name twice as she pushed the standing lift back into the bathroom. The AP was not on camera once she moved the lift into the bathroom, but said to the resident, "You passed out, I'm going to get help."

Progress notes indicated staff notified the nurse of the incident and the nurse assessed the resident. Several hours later, the resident complained of arm and shoulder pain and asked to go to the hospital. The nurse called 911 and the resident went to the hospital by ambulance and was admitted for treatment of a closed collar bone fracture.

Review of the resident's hospital records indicated the resident told hospital staff she "passed out" in the bathroom when she stood up but did not hit her head. Scans showed she had a mildly displaced left mid clavicle (collarbone) fracture.

During an interview, the AP said she had transferred the resident many times with the standing mechanical lift and never had the resident faint. The AP said she and a second staff member were getting ready to transfer the resident off the toilet, but the resident said she needed a little more time. The second staff member left to answer a resident call light and said she would be right back. About 30 seconds later, the resident said she was done and wanted to get off the toilet right away. The AP said the resident repeated she wanted to get off the toilet even though the AP told her they needed to wait for the second staff person to return and help. The AP said she started the standing lift transfer on her own expecting the second staff person to be right back. The AP said the resident just fainted without any warning. The AP said she was shocked, scared and yelled for help. As she moved the resident back into the bathroom, the resident regained consciousness, was able to hang onto the handles and sit on the toilet while the AP went for help. The AP said she did not see the in-room camera footage of the incident

and she was not aware she yelled “damn it” until the internal investigation. She told management she did not swear at the resident, it was just from fear. The AP said she was suspended a few days during the investigation then retrained on using the standing mechanical lift, which she knew always required two people. The AP said it was poor judgement on her part using the lift by herself.

The second staff member who worked that shift said she did not remember much about the incident.

During an interview, nursing management said an internal investigation was done. The AP was suspended pending the investigation outcome and then retrained on proper use of the standing mechanical lift. She was given a written warning for her language during the incident. Management said the resident was reassessed and switched to a full mechanical lift for transfers instead of the standing mechanical lift due to leg weakness.

During an interview, the family member said they were notified of the incident. The family member said the resident fainted on the toilet once before but did not think the standing mechanical lift was involved. He said he felt there was no intentional harm of the resident by staff members and no concern about the AP swearing when the resident fainted. The family member said the AP was the resident’s favorite staff member.

The resident was not available for an interview.

In conclusion, the Minnesota Department of Health determined abuse and neglect were 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.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

"Abuse" means:

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

**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

(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:** Attempted, not available to interview.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility conducted an internal investigation into the incident, provided medical treatment to the resident in a timely fashion, filed a report, retrained the AP and reassessed the resident for safety with transfer devices.

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

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>29576</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/21/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALL SAINTS SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1880 INDEPENDENCE DRIVE SHAKOPEE, MN 55379</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
0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER 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>#HL295761487C/#HL295766103M</p> <p>On August 21, 2023, 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 88 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL295761487C/#HL295766103M, tag identification 0510.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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>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.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 510 SS=E	<p><b>144G.41 Subd. 3 Infection control program</b></p> <p>(a) All assisted living facilities must establish and maintain an infection control program that</p>	0 510		

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

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0 510	<p>Continued From page 1</p> <p>complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control when unlicensed personnel (ULP)-D, failed to disinfect an standing mechanical lift between the transfers of two of two residents (R2 and R3) observed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>Findings include:</p> <p>R2's medical diagnoses included Type 2 diabetes, morbid obesity, weakness, difficulty walking, peripheral neuropathy, dizziness, kidney failure and heart failure.</p>	0 510		

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0 510	<p>Continued From page 2</p> <p>R2's service plan agreement dated January 1, 2023, indicated R2 received daily assistance with full mechanical lift transfers. Transfer instructions included: assist of two staff with full mechanical lift, XL sling, ensure all straps are secure and explain to resident what you are doing.</p> <p>R3's medical diagnoses included hypertensive heart disease with heart failure, stage 3 chronic kidney disease, and repeated falls.</p> <p>R3's service plan agreement dated May 25, 2023, indicated R3 required two staff for transfers for use of mechanical lift. Routine services included call AL/CS (assisted living/care suites) for transfer assist. Transfer instructions included: assist of two staff with full mechanical lift, ensure all straps are secure and explain to resident what you are doing.</p> <p>During an observation on August 21, 2023, at 11:19 a.m., ULP-D and licensed practical nurse (LPN)-I used the standing mechanical lift to transfer R2 from her recliner to her wheelchair. R2 grasped the handle bars while staff raised her to a standing position and transferred her. After R2's transfer, ULP-D moved the standing mechanical lift to R3's room without disinfecting the lift. At 11:30 a.m., ULP-D and a hospice staff member used the standing mechanical lift to transfer R3 from her recliner to her wheelchair. R3 grasped the handle bars while staff raised her to a standing position and transferred her. ULP-D moved the standing mechanical lift back to R2's room without disinfecting the lift.</p> <p>During an interview on August 21, 2023, at 10:35 a.m., ULP-F said she was trained on using the standing mechanical lift and staff needed to</p>	0 510		

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0 510	<p>Continued From page 3</p> <p>disinfect and inspect lifts before each use.</p> <p>During an interview on August 21, 2023, at 11:00 a.m., ULP-D said three residents in the Care Suites needed standing mechanical lift transfers and there was just the one lift in the unit for their resident transfers. ULP-D stated equipment was wiped down.</p> <p>During an interview on August 21, 2023, at 1:46 p.m., director of health services (DHS)-C said the standing mechanical lift slings don't go from one resident room to another so they do not need cleaning but the standing mechanical lift and total body mechanical lifts should be cleaned between each resident use with a bleach wipe. DHS-C said there was no equipment cleaning log.</p> <p>During an interview on August 21, 2023, at 1:46 p.m., executive director (ED)-A said she was not aware of any equipment cleaning logs.</p> <p>A policy titled Infection Prevention and Control Program, revised date April 2020, indicated all resident care items shall be cleaned, disinfected or sterilized according to the use of the item. Patient Care Equipment: Cleaning and disinfecting patient care equipment is an important process to inactivate bacteria, fungus and viruses. This type of disinfection is used for equipment that touches skin. These items may include: stethoscopes, oximeters, blood pressure cuffs, patient care lifts, house glucometers, tablets and cell phones.</p> <p>Time Period to Correct: Seven (7) Days</p>	0 510		