*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** HL31955033M
**Compliance #:** HL319550534C

**Date Concluded:** January 27, 2020

**Name, Address, and County of Licensee Investigated:**
Maple Hill Senior Living LLC
3030 South Lawn Drive
Maplewood, MN, 55101
Ramsey County

**Name, Address, and County of Housing with Services location:**
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN, 55427
Hennepin County

**Facility Type: Home Care Provider**

**Investigator's Name:** Michele Strahan RN
Special Investigator

**Finding: Substantiated, facility and 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.

**Allegation(s):**
It is alleged: The facility and alleged perpetrator (AP) neglected the client, on two separate occasions, when the AP did not answer the call light for several hours. The first time, the client attempted to get out of bed, fell and laid on the floor for several hours. The client sustained a shoulder fracture.

**Investigative Findings and Conclusion:**
Neglect was substantiated. The facility and the AP were responsible for the maltreatment. The AP neglected to provide the client a scheduled safety check and neglected to answer the client's call pendant for approximately five hours. The client fell after attempting to transfer herself from the bathroom and laid on the floor for approximately four hours. The facility failed to adequately assess the client's pain and functional status after the first fall. The client experienced a left shoulder fracture, however it was not discovered until nearly a month later when family requested an x-ray for the client's ongoing complaints of left shoulder pain while at the hospital for evaluation of a second fall.

The investigation included interviews with facility staff including administrative staff, nursing staff, and unlicensed staff. The investigator observed client and staff interactions. The investigation reviewed several medical records, including the client's, facility policies and procedures, staff schedules and personnel files. The investigation also included client and family interviews.

The client resided at the facility and her diagnoses included stroke, right sided weakness, and aphasia (difficulty speaking). She was alert but had a difficult time making her needs known and required to use a communication board. Staff were to allow her additional time for communication. The client used a wheelchair for mobility and had a history of falls.

The client's service plan included assistance of one staff to bathe, groom, dress, toilet, transfer, and ambulate. The service plan also included safety checks because she got herself up to the bathroom and required help to get back in bed. Staff were required to check on the client at 12:00 a.m., and 3:00 a.m.; staff were required to verify that the client was safe and in bed.

Call pendant records indicated one night at 12:40 a.m., the client pressed her call pendant. The call pendant record indicated a staff person acknowledged the call at 1:16 a.m. but did not answer the call pendant until 5:30 a.m. The call pendant was on for five hours and 10 minutes.

According to facility documentation, the client reported at approximately 1:30 a.m., she got up by herself to use the bathroom because no staff assisted her. When the client attempted to transfer herself back into bed, she fell onto the floor. The client's neighbor heard the client screaming for two hours. The client reported two unlicensed personnel (ULP) picked her up off the floor at approximately 5:30 a.m.

Initially the AP told the director of nursing (DON) at approximately 12:40 a.m., she assisted the client into the bathroom and back to bed, but was unable to clear the client's call pendant. At 5:30 a.m., the AP got ULP-N to help clear the pendant. The AP and ULP-N denied knowledge of the client's fall that night.

Later that morning, on the day shift, ULP-E stated she noticed bruises on the client's face near her eye and a bruise on one of her arms. ULP-E assumed the bruises were old so she did not report the client's bruises to the nurse. At approximately 7:00 p.m., the client told her family member she fell and waited on the floor for four hours for help. The family member called to report the fall to ULP-E, and she reported the fall to the nurse.

The facility conducted an internal investigation and reviewed cameras. The facility managers determined the AP did not go into the client's room for almost five hours. When questioned, the AP confirmed she did not complete the client's 3:00 a.m. safety check.
The client's record lacked a functional assessment of the client after her reported fall.

Two days later, the client complained of shoulder pain. According to the client's chart notes, a float registered nurse (RN) instructed the ULP to give the client Tylenol (pain medication) and place an ice pack. The float RN did not assess the client or document the location of the client's pain.

Approximately three and a half weeks later, the client reached for her shoe and fell out of her wheelchair. Staff sent the client to the hospital for evaluation.

The client's hospital record indicated she presented with abrasions to both knees, a bruise to her right eye and a forehead hematoma (swollen bruise). The client had a new complaint of right shoulder pain. The client's family reported she had ongoing left shoulder pain since a fall the previous month. Imaging revealed the client did not have any facial fractures nor a right should fracture, however did reveal a left shoulder fracture. The hospital admitted the client for renal insufficiency and pain. The hospital staff discharged the client back to the facility the next day.

The client's record lacked a RN functional assessment of the client following a hospitalization and a left shoulder fracture.

The float RN, who charted on the client's pain after her first fall, declined an interview. RN-G stated she could not recall if she assessed the client after her falls and hospitalization.

In conclusion, neglect was substantiated.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

**Vulnerable Adult interviewed**: Yes.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: No, the AP did not respond to multiple attempts to contact.

**Action taken by facility:**

The facility conducted an internal investigation and the AP was no longer employed by the facility.

**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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Hennepin County Attorney
Golden Valley City Attorney
Golden Valley City Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H31955 | A. BUILDING: _____ B. WING _____ | C 11/20/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MAPLE HILL SENIOR LIVING | 3030 SOUTH LAWN DRIVE MAPLEWOOD, MN 55109 |

| (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 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 11/20/19, the Minnesota Department of Health initiated an investigation of complaint #HL31955034C/#HL31955033M and #HL31955036C/#HL31955035M. At the time of the survey, there were #81 clients receiving services under the comprehensive license.<br><br>No correction orders were issued for #HL31955036C/#HL31955035M.<br><br>The following correction orders are issued for #HL31955034C/#HL31955033M: 0325 and 0865. | 0 000 | 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 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2) | |
| 0 325 | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights: | 0 325 | | |

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| 0 325 | Continued From page 1<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, the facility failed to ensure one of five clients reviewed (C1) was free from maltreatment. Staff neglected C1 when C1 fell on the floor, pressed her call pendant, and waited on the floor for almost five hours for staff to answer the call light. Several weeks later C1 fell, went to the hospital, and the hospital obtained a left shoulder x-ray due to onging shoulder pain. C1 suffered a left shoulder fracture from the first fall. On a subsequent night, C1 pressed her call button for assistance, and waited almost two hours for staff to respond.<br><br>Findings include:<br><br>On January 27, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and individual staff person 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. | 0 325 | No Plan of Correction required for tag 0325. Please refer to the public maltreatment report for details. | |
| 0 865 SS=G | 144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions<br><br>Subd. 9. Service plan, implementation, and | 0 865 | | |

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| 0 865 | Continued From page 2<br>revisions to service plan. (a) No later than 14 days<br>after the initiation of services, a home care provider shall finalize a current written service plan.<br><br>(b) The service plan and any revisions must include a signature or other authentication by the home<br>care provider and by the client or the client's representative documenting agreement on the services to be<br>provided. The service plan must be revised, if needed, based on client review or reassessment under<br>subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's<br>fee for services and how to contact the Office of the Ombudsman for Long-Term Care.<br><br>(c) The home care provider must implement and provide all services required by the current service<br>plan.<br><br>(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.<br><br>(e) Staff providing home care services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interviews, and document review, the facility failed to provide services | 0 865 | | |

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| 0 865 | Continued From page 3<br><br>according to the service plan for one of five clients (C1) reviewed. Staff did not provide safety checks at night when C1 fell on the floor, pressed her call pendant, and waited on the floor for almost five hours for staff to answer the call light. C1 suffered a left shoulder fracture from the fall.<br><br>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).<br><br>The findings include:<br><br>C1's medical record was reviewed and her diagnoses included stroke, right sided weakness, and aphasia (difficulty speaking).<br><br>C1's vulnerability assessment dated 03/26/19, indicated C1 had difficulty speaking, and hemiplegia (weakness on one side). Staff were required to use a communication board, ask yes and no questions, and allow C1 additional time for communication. C1 was chair bound and required assistance with her wheelchair and with transfers.<br><br>C1's service plan dated 07/11/19, indicated C1 required the assistance of one staff to bathe, groom, dress, toilet, transfer, and ambulate. C1 required staff to escort her to meals. C1 required safety checks at 12:00 a.m., 3:00 a.m., for toileting assistance.<br><br>C1's vulnerability assessment dated 07/18/19, | 0 865 | | |

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| 0 865 | Continued From page 4<br><br>indicated C1 had a fall with a sacral fracture, and staff were required to assist C1 with all transfers.<br><br>C1's fall assessment dated 07/18/19, indicated C1 scored a nine, and a score of 10 or above indicated a high fall risk.<br><br>Call light audit times dated 9/12/19, indicated C1 pressed her call light at 12:40 a.m., and was closed, or turned off, at 5:30 a.m. The call light audit indicated a staff person acknowledged the call at 1:16 a.m. but did not complete the call light. The call light was on for five hours and 10 minutes.<br><br>The facility's internal investigation dated 09/13/19, indicated on 09/12/19, at 7:55 p.m., unlicensed personnel (ULP)-E told licensed practical nurse (LPN)-F that C1's family member was upset because C1 had fallen during the night and was left on the floor for several hours. C1's neighbor heard C1 screaming from 1:00 a.m., to 3:00 a.m. C1 told the director of nursing (DON)-H that two ULPs picked her up off the floor at approximately 5:30 a.m. C1 told DON-H at approximately 1:30 a.m., she transferred herself into her wheelchair, and took herself to bathroom because no staff had assisted her that night. C1 was unable to transfer herself back into bed and fell onto the floor. C1 had bruises to her right lower arm and hand. The facility determined the whereabouts of ULP-J from a camera on the memory care unit. The camera showed ULP-J spent most of the night in the memory care unit, and did not answer C1's call light for almost five hours. ULP-J admitted she did not complete C1's 3:00 a.m., safety check.<br><br>C1's progress note dated 09/16/19 at 1:18 p.m., indicated a float registered nurse (RN) wrote late | 0 865 | | |

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| 0 865 | Continued From page 5<br><br>entry for 09/14/19, at 12:10, p.m., the ULP called the nurse to report C1 crying in discomfort. The float RN instructed the ULP to give C1 Tylenol and use an ice pack if Tylenol not effective.<br><br>C1's incident report dated 10/07/19, indicated C1 fell in her living room. C1 hit her head and sustained bruising to her right head and facial area. Staff called 911 and paramedics arrived at 8:20 a.m. C1 went to the hospital.<br><br>C1's hospital records dated 10/07/19, indicated C1 fell from a chair while reaching for a shoe. C1 presented with bi-lateral (both) knee abrasions, a bruise to her right eye and a forehead hematoma (swollen bruise). C1 had a new complaint of right shoulder pain. C1's family reported she had ongoing left shoulder pain since a fall the previous month. Imaging revealed C1 did not have any facial fractures nor a right should fracture, however did reveal a left shoulder fracture. The hospital admitted C1 for renal insufficiency, and pain. The hospital staff discharged C1 back to the facility the next day.<br><br>During an interview on 11/20/19, at 1:55 p.m., C1 stated she fell out of her chair onto the floor. She did not recall the date or time. C1 stated she pressed her call pendant and no staff came to help her for five hours. Another time she fell out of a chair and hit her head.<br><br>During an interview on 11/25/19, at 2:25 p.m. ULP-E stated she cared for C1 and noticed bruises on C1's face near her eye and a bruise on her arm. ULP-E stated she did not recall the date, but she worked a double that day (referring to C1's first fall), on the day and evening shift. ULP-E did not get a report from the night shift | 0 865 | | |

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| 0 865 | Continued From page 6<br><br>because she came in late and another ULP told her everything was okay. ULP-E stated she did not know C1 fell on the night shift, and did not know C1's bruises were new. At approximately 7:00 p.m., C1's son asked where C1 got the bruises. ULP-E reported the bruises to LPN-F.<br><br>During an interview on 11/25/19, at 3:10 p.m., LPN-F stated she got a call from C1 family member that C1 fell. She could not recall the exact date or time. C1 fell during the night but the facility was unaware. She could not recall details.<br><br>During an interview on 11/25/19, at 3:53 p.m., DON-H stated when the facility staff became aware that C1 had a fall on the shift they completed a detailed investigation. She interviewed several clients, several staff, reviewed call light audits, medical records, and camera footage from memory care unit. DON-H determined that ULP-J did not answer C1's call light for several hours. ULP-J mostly likely assisted C1 back into bed at 5:30 a.m.<br><br>During an interview on 12/02/19, at 9:04 a.m., family member (FM)-K stated C1 fell onto the floor in the middle of the night and waited for four hours for someone to answer her call light. The next day C1 complained of shoulder pain. C1 fell again several weeks later, facility staff sent her to the hospital, and the hospital found C1 had a shoulder fracture from her first fall.<br><br>A facility policy titled Service Plans dated 07/10/17, indicated the home care provider must implement and provide all services required by the current service plan.<br><br>TIME PERIOD OF CORRECTION: 7 Days | 0 865 | | |

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