Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354471060M
Compliance #: HL354478385C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee Investigated:
Park's Place
18040 Medina Road
Plymouth, MN, 55446
Hennepin County

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

Evaluator's Name: Angela Vatalaro, 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(s):
The alleged perpetrator (AP), a staff member, neglected the resident when the AP failed to provide safety checks as indicated on the plan of care. The resident fell.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to support the AP failed to provide the resident's safety checks. The AP experienced technical difficulty with the electronic charting system during shift, however the AP documented two-hour checks on paper rounding records the facility used for monitoring sleep patterns.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, overnight rounding records, and personnel file. Also, the investigator toured the facility and observed staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included osteoporosis (decreased bone mass.) The resident's service plan included one staff assistance with transfers, and safety checks every two hours. The resident's assessments indicated the resident was oriented to person, forgetful, confused, had impaired decision making, and memory loss. The resident had recurrent falls, was impulsive, and would forget to ask for assistance with transfers. The resident used her lower extremities for locomotion in a wheelchair and was considered wheelchair bound. The resident was on hospice services.

Overnight rounding records indicated the day of the fall, the resident was observed asleep in her room at 10:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m.

At approximately 7:45 a.m., the facility internal investigation indicated the resident was found sitting on the floor in the bathroom. The on-call nurse was contacted. Two staff assisted the resident off the floor using a gait belt. Vital signs were checked, pain medication was provided, and hospice services was updated. Forty-five minutes later, the resident continued to show signs of pain despite the earlier pain medication. Due to the resident's history of fractures related to falls, the nurse notified the resident's provider for orders for an X-ray. Hospice services arrived and started the resident on as needed pain medication for better pain management. The resident received two doses of the medication but continued to have pain. The facility sent the resident to emergency room for evaluation.

Hospital records indicated the resident diagnosed with a right acetabulum (socket of hip joint) fracture. The hospital recommended non-operative management. Five days later, the resident discharged from the hospital to a different facility for rehabilitation.

Three weeks after that, the resident returned to the facility.

During an interview, a nurse stated morning staff found the resident on the floor when they went to provide morning cares. The resident was assessed, hospice was updated, the resident received pain medication, and staff continued to observe the resident. The resident was unable recall any details surrounding the fall due to her cognition. The facility obtained orders for an X-ray. The resident was still in pain while the facility awaited the X-ray results. The resident was sent to the emergency room for evaluation. The resident had not had any other falls at the facility or any occasions of self-transferring. Prior to admission, the resident had fallen and sustained a fracture. At times, the resident had back and/or hip pain caused from the prior injury.

During an interview, leadership stated the resident's last safety check should have occurred at 6:00 a.m. The AP was unable to recall the hour of day/time she last laid eyes on the resident during the shift however she said when she did, the resident was sleeping. The AP said she completed the two-hour safety checks. The AP had technical difficulty electronically documenting the safety checks in the resident's record. Leadership checked the system and

confirmed the electronic charting device application was not loading correctly. The AP documented two-hour checks on the overnight rounding sheets which the facility used for monitoring resident sleep patterns. Leadership stated based on how the resident was found the resident may have attempted to get out of bed and fell.

During an interview, the AP said she specifically remembered conducting the resident's initial check and could not remember the remainder of the night or the hour of day/times she conducted the resident's other safety checks. The AP said when observed, the resident was in bed sleeping. The AP said there were no changes or concerns with the resident during shift, the resident slept soundly.

In conclusion, the Minnesota Department of Health determined neglect was 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: No. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility assessed the resident after the fall, provided pain management, comfort medications, updated the resident's family and medical providers. The facility coordinated an X-ray and sent the resident to an emergency room for an evaluation. The facility conducted an internal investigation, educated the AP on what to do when experiencing technical difficulties for service delivery documentation, and was re-educated on safety check expectations.

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
	35447	A. BUILDING: _____ B. WING _____	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKS' PLACE	18040 MEDINA ROAD PLYMOUTH, MN 55446

(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 April 25, 2024, the Minnesota Department of Health initiated an investigation of complaint #H354478385C/#HL354471060M. No correction orders are issued.	0 000		