Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356381120M
Compliance #: HL356388462C

Date Concluded: May 28, 2024
Revised Date; January 31, 2025

Name, Address, and County of Licensee Investigated:
Liberty Mathan Health Care Services LLC
3248 Sprague Avenue
Anoka, MN 55303
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator
Revised By: Will Davis, Reconsideration Analyst

Finding: Substantiated, individual responsibility

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) neglected the resident when he left the resident on the floor for five hours after the resident fell.

Investigative Findings and Conclusion:
Upon reconsideration, the findings of this report were changed to substantiated.
~~The Minnesota Department of Health determined neglect was inconclusive~~. The resident experienced a fall in the bathroom and the AP, an unlicensed personnel (ULP), moved the resident back to his bed prior to contacting the nurse. The resident had sustained a left leg fracture. The AP reported conflicting versions of the incident events. The resident's physician stated with the resident's medical history, spontaneous fractures could occur. The investigation

determined there was an unreasonable delay in treatment of the VA due to the actions of AP and ULP-1.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions and care tasks with residents.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis and traumatic brain injury. The resident's service plan included assistance with incontinence cares and bathing. The resident's assessment indicated the resident was alert and oriented, had swelling to lower extremities at baseline, walked independently, and a history of falls.

One morning during, the AP woke the resident to obtain his blood sugar reading and noted the bed to be wet from an incontinence episode. The AP instructed he resident to go the bathroom while he changed the bed. The AP heard the resident yell from the bathroom and noted him to be on the floor. The AP assisted the resident back to his room and notified the nurse.

The resident's daily log notes indicated the fall occurred at 6:15 a.m. The AP assisted the resident to bed, had stable vital signs, and received Tylenol for pain. Staff did not note any injuries at that time.

The facility incident report indicated the resident fell at 6:20 a.m. and the AP discovered the resident on the floor at 6:30 a.m. The AP noted the resident's left leg, left buttock and left foot were pink in color. The resident said it hurt to move his leg. The AP lifted him off the floor and assisted him to bed. The AP documented the assistance occurred at 7:00 a.m. and he left a message for the registered nurse (RN) at 7:06 a.m. An incident follow-up note by the RN indicated she woke up to missed calls and text messages about the resident's falls and notification he was sent to the hospital.

The resident's hospital record indicated the resident reported to hospital staff the fall happened the night before and he was on the floor for five hours. The resident Xray results indicated left tibia and fibula (bones of the lower leg) fracture. The resident required surgical repair.

The facility internal investigation conducted three days later, indicated the AP stated upon arrival to the bathroom, the resident was laying on his left side and refused his help while calling him vulgar names. The AP instructed the resident to scoot out to the hallway, then the AP helped him off the floor and to his bed. The AP checked the resident's blood pressure and his left leg, both appearing normal. The AP gave the resident Tylenol for pain. The AP notified ULP-1 of the resident's fall when she arrived for her shift around 7:00 a.m. At 7:15 a.m., ULP-1 noted the resident resting in bed. When ULP-1 woke the resident at 9:00 a.m. for breakfast, the

resident reported pain to his left leg. ULP-1 observed the leg to be purple in color and swollen. ULP-1 sent a text message to the RN and called ULP-2, who directed ULP-1 to call 911.

During an interview, ULP-1 stated when she arrived to work around 7:00 a.m., the resident appeared to be asleep in his bed. ULP-1 stated the AP told her the resident had a fall and was resting. ULP-1 stated the AP told her he heard the resident fall in the bathroom, and he walked the resident back to his room with no problem. ULP-1 stated she was not sure what time the fall happened. At 9:00 a.m., the resident complained of pain in his left leg. ULP-1 stated when she looked at the leg, she saw it was swollen and purple. ULP-1 called 911. ULP-1 stated if a resident falls and cannot get up on their own, they must notify the nurse, then call 911.

During an interview, the AP stated the resident fell in the bathroom around 6:00 a.m. The AP stated he lifted the resident up, put the resident's arm around his shoulder and helped him walk back to his room. The AP stated the resident was able to put weight on his left leg and there was no swelling or bruising present. The AP stated the resident was cursing him out when they got to his room and would not allow the AP to assist him in to bed or change the soiled pants he was wearing. The AP stated he attempted to convince the resident to allow him to assist him into bed three times, but the resident did not allow it. The AP stated the resident was on the floor when the day shift staff came into the facility. The AP stated if a resident falls and cannot get up, they are to sit them up, call 911, then call the nurse. The AP stated they are to call the nurse after they help the resident up.

During an interview, the nurse stated there had never been any concerns or complaints from residents or staff about the AP. The nurse stated she expects staff to call 911 if a resident falls and cannot get up on their own; staff should not be lifting residents off the floor. The nurse stated the AP notified her via text message at 7:06 a.m. about the resident having a fall at 6:00 a.m. The nurse stated she did not give any directive to the AP at that time due to being under the impression the resident had returned to his bed without any injury or concern present. The nurse stated she received another text message at 9:20 a.m. from ULP-1, notifying her ULP-1 sent the resident to the hospital. The nurse stated she did not believe the staff mishandled the incident.

During an interview, a family member stated while in the hospital, the resident told the surgeon he fell around midnight. The surgeon told the family member he did not believe the fall occurred at 6:00 a.m., that he believed the fall must have occurred around midnight due to the extensive swelling. The family member stated she received three versions of the story on the incident. The family member stated she did not feel it was appropriate to call emergency medical services at 9:22 a.m. if a fall occurred at 6:00 a.m. The family member stated she did not have the resident return to the facility because she felt the staff purposely left the resident on the floor all night.

The resident was not able to complete an interview.

The investigator attempted to interview the resident's medical provider, however phone calls were not returned.

The facility's fall policy directed ULP staff to evaluate the resident after a fall and determine if the resident was safe to be assisted. The policy directed ULP staff to call 911 when a resident was unable to move or had an injury. Contacting the nurse was the fourth directive of the list.

Upon reconsideration, the findings of this report was changed to substantiated against AP and ULP-1.
~~In conclusion, the Minnesota Department of Health determined neglect was inconclusive.~~

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 and the accused was responsible of the maltreatment.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.
(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: No, unable to complete interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility staff administered Tylenol for pain and sent the resident to the hospital.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35638	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY MATHAN HEALTH CARE SERVICES, LLC	3248 SPRAGUE AVENUE ANOKA, MN 55303

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL356388462C/HL356381120M On April 3, 2024, 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 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL356381120M/HL356388462C, tag identification 2310.	0 000	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 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 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 evaluators' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to implement a process aligned with nursing standards of care to require unlicensed personnel (ULP) to consult with a nurse for directive in response to falls prior to providing intervention for one of one residents reviewed (R1). R1 experienced a fall and the fall policy directed ULP to evaluate and help a resident up if it was safe to do so, without consulting with a nurse. ULP-B assisted R1 to his bed and two hours later was transported to the hospital with a fractured leg. This deficient practice had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident'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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Minnesota Statute 148.171, subd. 15, Nurse Practice Act, indicates the registered nurse (RN) scope of practice includes providing comprehensive assessment of the health status of a patient (resident) through the collection and	02310		

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02310	Continued From page 2 analysis of data to address changes in the patient's condition. The Agency for Healthcare Research and Quality document titled "The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities" dated October 2005, chapter two, page ten, indicated an immediate evaluation by a nurse should be completed after a resident falls, to include a review of the resident systems and description of injuries. Upon evaluation the nurse should stabilize the resident and provide treatment if necessary. The licensee-provided policy titled "Fall Intervention" dated September 5, 2024, indicated step one directed ULP to respond immediately after a fall. Step two directed ULP to evaluate and monitor the resident and help the resident up if it was safe to do so. Step three directed ULP to call emergency response immediately if a resident is not able to move and staff cannot help resident to a sitting position. Step four directed ULP to notify the RN immediately by calling the on-call number. The policy lacked directive based on standards of care to require ULP to collect data to report to the RN after a resident fall for the RN to assess the resident's health status prior to providing directive of treatment or intervention for the ULP. R1's diagnoses included osteoporosis and traumatic brain injury. R1's service plan dated January 11, 2023, indicated R1 received staff assistance with incontinence cares, medication administration and behavior management. The facility incident report dated December 24, 2023, indicated ULP-B discovered R1 on the bathroom floor at 6:30 a.m. and R1's time of	02310		

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02310	Continued From page 3 injury was 6:20 a.m. The report indicated R1's left leg, left buttock and left foot were pink in color. R1 stated it hurt to move his leg and ULP-B helped R1 to his room. ULP-B documented the time of treatment at 7:00 a.m. and then left a message for RN-C at 7:06 a.m. An incident follow up note on R1's incident report dated December 24, 2023, at 5:08 p.m., by RN-C indicated she woke up to missed calls and text messages about R1's fall. ULP reported they sent R1 to the hospital. An incident follow up note on R1's incident report dated January 16, 2024, by RN-C, indicated staff reported R1 did not have anti-skid footwear on his feet. The report indicated RN-C provided education to all staff to always encourage R1 to put on socks or shoes to prevent falls. R1's hospital record dated December 24, 2023, indicated R1 admitted to the hospital for a fracture of his left leg and required surgical intervention. The facility internal investigation report dated December 27 and 28, 2023, indicated R1 was laying on his left side, not able to get off the bathroom floor and refused ULP-B's help. ULP-B stated he was unable to assist R1 off of the floor because of his position in the [bathroom] and instructed R1 to scoot himself to the hallway where ULP-B then lifted R1 up from the floor to assist into bed. Once in bed, ULP-B checked R1's blood pressure and looked at his left leg, which appeared normal. ULP-B gave R1 Tylenol for pain. ULP-B updated ULP-A when she arrived in the morning. ULP-A stated at 7:15 a.m. R1 was resting in his bed during rounds. At 9:00 a.m., when she woke R1 for breakfast he reported left	02310		

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02310	Continued From page 4 leg pain. ULP-A stated R1's leg was swollen and purple. ULP-A stated she sent a text to RN-C and called ULP-D (lead staff) who instructed her to send R1 to the hospital. During an interview on April 5, 2024, at 3:00 p.m., ULP-B stated when R1 was unable to get up from the floor, he lifted him up off the floor. ULP-B stated you call the nurse after you help the resident up. ULP-B stated staff are to call 911 if the resident cannot move or there is an injury. During an interview on April 8, 2024, at 2:00 p.m., RN-C stated past 9:00 a.m., she saw the text from ULP-B at 7:06 a.m. At 9:20 a.m., ULP-A text her indicating R1 said his leg hurt and she called an ambulance. RN-C stated at 10:06 a.m., she responded to ULP-A and wrote "good idea." RN-C stated if a resident cannot get up on their own, staff are to call 911 and should not lift a resident. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		