Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL360219246M
Compliance #: HL360216962C

Date Concluded: May 2, 2024

Name, Address, and County of Licensee Investigated:
The Preserve of Roseville
2600 Dale St N
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Inconclusive

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 during a shower. The resident slipped, went to the hospital and suffered a fractured tibia.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. During an overnight shift the resident developed knee pain during a shower. AP1 reported the resident had knee pain because she slipped in the shower but did not fall because she assisted AP2 with the transfer. AP1 also reported the resident had a "bad knee" with previous complaints of knee pain. The day shift unlicensed personnel (ULP) assisted AP1 with transferring the resident from the shower back to her bed. The ULP found it unusual to see the resident sitting in the shower chair when she normally stood during a shower and stated the resident did not have knee pain prior to the incident. AP2 failed to respond to a subpoena for interview. The facility failed to interview AP2 on the internal investigation document. The nurse reported AP2 told her she did not go into the resident's room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the physician who did not respond to an interview request. The investigation included review of incomplete resident records, a facility internal investigation, personnel files, and related facility policy and procedures. Also, the investigator observed staff caring for a resident who had an unwitnessed fall.

The facility underwent a receivership initiated by the former owner's financial institution with a change in management company and ownership. The management company did not have access to the previous management company's records and only had current records of the resident from their start of care, approximately three months after the incident. The previous management company provided some records requested for the investigation.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and dementia. The resident's service plan included assistance with bathing and medications. Staff were to apply lotion after her shower. Her service plan indicated she was continent of bladder and bowels, independent with walking and had mild to moderate disorientation. She received safety checks every two hours. The resident's record lacked updated assessments. The assessment provided by the facility failed to include how many staff the resident needed assistance with during showers, why she required a shower chair or if she preferred showers to baths.

The resident's progress notes indicated in the morning, the nurse received report from ULPs the resident was unable to bear weight on her right leg, had right knee pain and was crying out in pain. The nurse examined the resident and contacted the physician to get an x-ray of the resident's knee. The x-ray indicated the resident had a fractured tibia (shinbone). The nurse contacted the resident's physician and family member. The resident went to the hospital for assessment and admitted for surgery. The nurse conducted an internal investigation.

Review of hospital records indicated the resident complained of right knee pain but did not recall falling. She had age-related osteoporosis (fragile, brittle bones), a new right tibia fracture and a torn right lateral meniscus (knee cartilage). The resident had open reduction surgery to repair the fracture.

The resident went to transitional care after the hospital and then transferred back to the facility. She was not able to walk after her leg surgery. She enrolled in hospice and died a few months later.

The facility's internal investigation included a statement from the ULP. The ULP reported AP1 and AP2 were both in the resident's room mopping the floor at the start of her shift. AP1 asked her to assist her with a transfer of the resident out of the shower and the resident screamed in pain when standing. The ULP said AP1 said "it's just her bad knee." The ULP stated the resident

never sat on a shower chair and always stood during showers. The ULP and two evening shift ULPs reported the resident was walking independently per normal prior to the incident. The internal investigation also included a written statement by AP1. AP1 wrote she was doing the last rounds of the overnight shift when AP2 asked her to help clean the resident, who had soiled herself and her apartment. AP1 and AP2 changed the resident's soiled clothes and gave her a shower. When the resident stepped into the shower, her feet slipped "a little bit" but she did not fall because AP1 and AP2 held her under her arms for support. They seated the resident on her shower chair. The resident said her knee hurt and it appeared slightly swollen to AP1. AP2 left to assist another resident while AP1 finished showering the resident. AP1 told day shift staff about the resident's knee pain and said the resident had past complaints of knee pain. AP1 told day shift staff she applied a pain ointment to the resident's knee after the shower.

The facility internal investigation failed to include an interview with AP2. Documentation of the hallway video indicated the nurse did not see AP1 and AP2 go into the resident's apartment together and the only time two ULP entered was when AP1 and the ULP helped the resident transfer from the shower. The internal investigation failed to include what times during the overnight shift the nurse reviewed or if at any time one staff member entered the room rather than two. The internal investigation failed to include what time events of the incident occurred from the time of injury in the shower until the nurse progress note of evaluating the resident later in the morning.

The resident's medication list included an order for pain gel scheduled application three times a day at 8:00 a.m., 2:00 p.m. and 8:00 p.m. The resident's medication administration record indicated the on day of the incident and the previous two weeks the pain gel was not available to administer due to waiting on a new supply from the family.

During an interview, AP1 said the resident was in bed when she checked on her about an hour earlier. When AP2 checked on the resident, she found the resident had a bowel movement in bed and asked AP1 to help clean her. The resident was "hit or miss" with showers, but that night she was cooperative and did not struggle or yell. AP1 said wipes would not have been enough to clean the resident. AP1 said the resident complained her knee felt different as they walked her to the bathroom for her shower. She lost her footing as she entered the shower but did not fall. She sat on her shower chair without any complaints of knee pain but after the shower she said her knee hurt. AP1 looked at the resident's knee and it did not appear swollen, but since the resident said it hurt, she applied pain cream.

During an interview, the day shift ULP said she helped AP1 dress the resident who said her knee hurt and was in "agony." AP1 did not say what happened and the resident could not say why her knee hurt. The ULP said the resident had a shower chair but resisted using it and preferred to stand; therefore, she was not sure what happened, either an accident or maltreatment.

During an interview, the nurse said she believed AP1 and AP2 neglected the resident during the shower. The resident had a shower bench and the nurse alleged AP1 and AP2 probably forced

her to sit down on it, she fought it, and maybe twisted her leg. The nurse said during the internal investigation AP1 and AP2 “pointed fingers at each other.” When interviewed by the nurse, AP2 said she did not go into the resident’s room. The nurse said she reviewed hallway video that showed AP2 went into the resident’s room during the overnight shift, but not AP1. The nurse said neither AP1 nor AP2 completed an incident report, which was required.

During an interview, a manager said despite an extensive interview process with overnight and day shift staff, there was no conclusion on the cause of the resident’s injury. The video cameras reviewed faced the exit doors, so when they viewed the video, they could only see who walked down a hallway, not the rooms staff entered.

The resident’s family member said the resident hated showers in the last few years and could get combative. The family member stated the facility informed her about the resident’s knee injury. The family member said she wondered if the resident had osteoporosis but there was no definite osteoporosis diagnosis in her medical history. The family member said the nurse investigated the incident but had not come to any conclusion when she asked for an update.

During a phone call with AP2 requesting an interview, she said she would call back due to poor call quality but did not. AP2 did not respond to an interview subpoena.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

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.

Vulnerable Adult interviewed: Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP1. No, AP2 failed to respond to interview requests and a subpoena.

Action taken by facility:
An internal investigation was conducted.

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
	36021	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESERVE OF ROSEVILLE	2600 DALE STREET NORTH ROSEVILLE, MN 55113

(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 2, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL360216962C/#HL360219246M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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 Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State 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.	