DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362528424M
Compliance #: HL362525598C

Date Concluded: April 16, 2024

Name, Address, and County of Licensee Investigated:
The Pillars of Prospect Park
22 Malcolm Avenue
Minneapolis, MN 55414
Hennepin County

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

Evaluator's Name:
Jennifer Segal RN, BSN
Special Investigator
Reconsideration Analyst: Jacci Nickell

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), facility staff, neglected the resident when the AP failed to obtain a second staff to transfer the resident using a mechanical lift. The lift tipped over while the resident was suspended in the lift and the resident required surgery.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. ~~The facility was responsible for the maltreatment.~~ The facility was aware the resident was at risk for injury when being transferred with the mechanical lift on the carpeting in the bedroom. ~~The facility failed to implement interventions to ensure staff could safely transfer the resident in the bedroom using the mechanical lift.~~ The resident fell out of the lift and sustained a hip fracture.

The investigator conducted interviews with facility staff including administrative, nursing, maintenance, and unlicensed staff. The investigation included review of hospital records, facility medical records, internal investigation, personnel files, staff training and related facility policy and procedures. Also, the investigator observed resident cares and interaction of staff and residents at the facility.

The resident resided in an assisted living facility with diagnoses including multiple sclerosis (chronic and progressive brain and spinal cord disease) and spastic paraplegia (progressive weakness and stiffness in lower extremities). The resident's assessment indicated the resident required assistance from two, and occasionally three staff, and a full body mechanical lift for all transfers. The resident used a power wheelchair and navigated independently when in the chair. The service plan included assistance with dressing, toileting, and transferring. The resident's family member provided twenty-four-hour care in addition to facility staff.

A facility meeting summary indicated facility management were concerned the resident was not safe being transferred with the mechanical lift in the bedroom due to the carpeted surface and the resident's obesity. The summary indicated the residents case worker would work with the facility and replace the carpet in the bedroom with vinyl flooring.

The residents progress notes indicated staff were directed not to transfer the resident in the bedroom due to the risk of injury pushing the resident in mechanical lift on carpeted surface. In addition, the resident's bed was not appropriate size and deemed unsafe. The resident slept in a reclining chair in the living room while waiting for the new mattress and carpet removal.

Approximately five months later a facility internal investigation indicated the resident fell out of the mechanical lift when being transferred by the AP and the resident's family member. The report indicated the AP and family member were transferring the resident out of bed using the mechanical lift. The lift tipped sideways, and the resident fell to the floor. The resident complained of pain in his left leg, was transferred to the hospital, and admitted with a fractured femur (hip) and required surgical repair.

The facility investigation indicated several previous discussions were had with the resident and family regarding safety concerns with transferring the resident in the carpeted bedroom with the mechanical lift. The report indicated "carpeting bedroom is a safety factory [sp], which has been discussed with [family] and resident multiple times prior as mechanical Hoyer lift unsafe to push on carpet." The family member stated the carpet likely played a factor because the wheels would have "slid" rather that tipped over. The investigation indicated the facility would implement interventions including removing the carpet in the residents' bedroom, staff retraining on mechanical lifts, and therapy would reevaluate safety and needs for bariatric equipment.

During interview a nurse stated staff had ongoing concern for resident and staff safety while transferring the resident with the mechanical lift.

During interview the resident's family member stated the morning of the incident the family member requested to assist the AP rather than wait for a second staff member. The family member stated they believed the mechanical lift tipped due to the carpet in bedroom and the of transferring the resident from the new mattress. The family member stated they did not believe the fall would have been prevented if a second staff member was present. The family stated they transferred the resident regularly using the mechanical lift without a second person.

During interview the AP stated the morning of incident the resident's family member requested to be the second person to assist with the transfer. The AP stated that morning the resident was in his bedroom lying in bed for the first time and the AP assumed the mechanical lift transfer would be like all other mechanical lift transfers from a bed. The AP stated the resident's family provided frequent care and assistance with transferring. The AP believed the lift tipped due to the resident's weight and the difficulty in turning the lift ninety degrees on carpet from bed to chair was not feasible.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

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.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility staff called 911, investigated the incident, retrained staff, made required reports and ensured the carpet was replaced.

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

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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36252	A. BUILDING: _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(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: #HL362525598C/#HL362528424M On February 27, 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 110 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued #HL362525598C/#HL362528424M tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident, R1, reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	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.	