Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL362972321M
Compliance #: HL362971440C

Date Concluded: 10/03/2024

Name, Address, and County of Licensee Investigated:
Carelink Skilled Nursing & HC
15804 Everglade Ct
Apple Valley, MN 55124
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, 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), facility staff, neglected the resident when they dragged the resident by the arms during a seizure causing a dislocated right shoulder. In addition, the AP failed to assist the resident during an episode of hypoglycemia (low blood sugar.)

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The AP denied the resident experienced a seizure and low blood sugar during the shift that she was working. The resident had varying accounts of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's health and wellness therapist. The investigation included review of facility policy and procedures, resident records to include a list of triggers, signs of escalation, coping interventions, and dissociative guidelines.

The resident resided in an assisted living facility. The resident's diagnoses included psychogenic seizures (non-epileptic seizure caused by stress, emotions, or psychological issues), anxiety, depression, intellectual disabilities, and pre-diabetes. The resident's service plan included assistance with medication and behavior management. The resident's assessment indicated the resident had a history of non-epileptic seizures and staff would support the resident as needed.

The resident reported an event of a seizure to three of her outside health care support workers. The resident reported that one afternoon she had a seizure in the bathroom. The resident stated the AP dragged her by both arms to the hallway until the seizure was done. When the resident recovered, an application on the resident's phone, notified the resident of a low blood sugar that the resident also reported to the AP. In one of the reports the resident stated the AP dragged her to her room and put the resident in a pile of stuffed animals until she recovered.

The resident record indicated during the time of the alleged incident the resident's blood sugars were within the normal range and not low.

During an interview, the nurse stated the resident experienced disassociation (mental process where a person disconnects form their thoughts, feelings, memories, or sense of identity). The resident did not have a diagnosis of seizures. The nurse stated during the disassociation episodes, the resident blinked her eye's, shook one arm or leg, and wrote notes indicating she could not speak. The nurse stated she was not notified by the AP or the resident that this incident occurred. The nurse stated all staff members were trained what to do when this resident displayed seizure like activity, disassociation, and anxiety. The nurse stated staff members are trained not to physically handle the resident and to contact the nurse for advice and assistance.

During an interview, the AP stated she did not see the resident have a seizure on the day she reported it to the support workers. The AP stated that if the resident had a seizure, she would have called the nurse and an ambulance. The AP stated that on the day in question the resident did not report having shoulder pain and her blood sugar was within normal limits.

During an interview, the resident stated she had a seizure and the AP dragged her out of the bathroom and dislocated both shoulders. When she recovered from the seizure, the resident was in extreme pain and went to a clinic for treatment, however there is no documentation of the appointment.

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

Action taken by facility:
No action taken.

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
	36297	A. BUILDING: _____ B. WING _____	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARELINK SKILLED NURSING & HC	15804 EVERGLADE COURT APPLE VALLEY, MN 55124

(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 August 9, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL362971440C/#HL36272321M. No correction orders are issued.	0 000		