Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL389831941M
Compliance #: HL389839652C

Date Concluded: July 12, 2024

Name, Address, and County of Licensee Investigated:
Personal Care Senior Living
3850 Jefferson Street Northeast
Columbia Heights, Minnesota 55421
Anoka County

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

Evaluator's Name: Nicole Myslicki, 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 facility and the alleged perpetrator (AP) neglected the resident when facility staff found the resident face down on the floor with medical equipment on top of her. The resident had bleeding on her hand and vomited. Emergency medical services (EMS) transferred the resident to the hospital. The AP left the facility before staff found the resident on the floor and did not return.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident did not fall from a mechanical lift but fell from a power lift chair onto the floor. An error in therapeutic conduct occurred by failing to assess and implement an intervention to help prevent the resident from inadvertently pressing the chair's remote. However, the resident did not require significant medical intervention or treatment.

The Minnesota Department of Health determined neglect was not substantiated against the AP. The AP left the facility before the resident fell, and only left after a miscommunication between her and facility staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed transfers with the use of a mechanical lift.

The resident resided in an assisted living facility. The resident's diagnoses included dementia. The resident's service plan included assistance with eating and medication administration. The resident's assessment indicated the resident needed help with sitting up, turning and repositioning, transferring with the use of a mechanical lift, and all activities of daily living. This assessment identified the resident as disoriented to place and time, and had moderately impaired decision-making.

An incident report indicated unlicensed personnel (ULP)-1 found the resident lying face down on the floor of her apartment with her head under the bed and sling for the mechanical lift on her back. The resident had a skin tear on her right hand and bruising on her face. Staff called 911 and notified the licensed assisted living director (LALD). This report indicated the resident did not fall from the mechanical lift. The facility-provided power reclining chair's remote had been on the arm rest. The resident inadvertently lifted the chair and fell when her arm rested on the remote. To prevent future falls, the facility would ensure the remote for the chair would be placed in the side pocket.

The resident's hospital record indicated the resident received a diagnosis of a closed head injury. She spent less than 48 hours in the hospital, having various tests and imaging completed to rule out injury. The trauma workup completed had been completely negative. The resident discharged and returned to the facility.

The facility internal investigation included interviews with staff and review of video surveillance. During an interview, the AP stated she last helped the resident around 6:00 p.m. when she assisted the resident with eating dinner. At that time, the resident remained in the power lift chair. After that, ULP-2 instructed the AP to leave and told her another staff person would come in to finish the shift. As the AP left the facility, she saw another staff member coming into the facility and assumed that was her replacement. Video surveillance showed the AP left the facility around 6:10 p.m. The staff member and ULP-3 came to the facility around 6:00 p.m., but not to work. Another resident had a birthday party the same evening as the incident, so ULP-3 and the other staff member came for the party. At about 6:30 p.m., ULP-3 entered the resident's room for a few seconds, looking for ULP-1. ULP-3 stated the resident had been seated in the power lift chair and appeared comfortable, noting the mechanical lift had not been near

the resident. At 8:25 p.m., ULP-1 found the resident face down on the floor of her apartment with the mechanical lift sling on her back. The resident vomited and had blood on her right hand. ULP-1 called ULP-2, and they called 911. Emergency medical services arrived and transported the resident to the hospital. Hospital staff reported the resident had no injuries other than the skin tear on the right hand and bruising around the left eye.

During an interview, ULP-3 stated she went to the facility the evening of the incident for another resident's birthday party. ULP-3 had been looking for a coworker and peeked into the resident's room. She saw the resident sitting in the power lift chair with the mechanical lift sling underneath her back. The resident faced the television and had either been watching a show or sleeping.

During an interview, the LALD stated part of the internal investigation included a reenactment of how the resident could have fallen. The LALD sat in the power lift chair and used the remote to raise the chair until she fell out. The LALD fell forward onto the ground, and the mechanical lift sling stayed on her back. Her position on the floor and sling on her back looked the same as how the resident looked. The LALD stated the resident returned to her baseline after the incident occurred.

During an interview, a nurse stated he did not complete an assessment to determine if the resident could use the power lift chair safely and as intended before the incident. The nurse thought the resident would not have been able to grab the remote and use it. Prior to the incident, the nurse did not determine a specific place for the remote to be kept. After the incident, the nurse instructed staff to keep the remote out of the resident's reach.

During an interview, the AP stated she did not transfer the resident herself with the mechanical lift because that required two staff. The AP fed the resident dinner in the chair within her apartment. After that, the resident wanted to get into bed. The AP left to find someone to help her with the transfer. The AP then spoke with ULP-2 who told her to go home, and someone would come in to cover the rest of the shift. After seeing another staff member come to the facility, the AP left between 6:00 p.m. and 6:15 p.m. The last time she saw the resident, the resident had been in the reclining chair.

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.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care;

Vulnerable Adult interviewed: No. The resident is deceased.
Family/Responsible Party interviewed: No. Attempts to reach the family were unsuccessful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and implemented the intervention of keeping the remote out of the resident’s reach while in the power lift chair.

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
	38983	A. BUILDING: _____ B. WING _____	C 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE SENIOR LIVING	3850 JEFFERSON STREET NE FRIDLEY, MN 55432

(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 May 21, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL389839652C/#HL389831941M and #HL389837206C/HL389839408M. No correction orders are issued.	0 000		