Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL389835164M
Compliance #: HL389838879C

Date Concluded: March 31, 2023

Name, Address, and County of Licensee Investigated:
Personal Care Senior Living
3850 Jefferson Street NE
Columbia Heights, MN 55432
Anoka County

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

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 neglected a resident when they failed to provide appropriate supervision of a resident who was assessed to be unsteady, and the resident fell. The resident fractured their hip and passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility nurse assessed the resident to require occasional assistance with walking when unsteady. The nursing assessment indicated the resident liked to walk throughout the day and placed the resident in an apartment near the staff desk. The facility documented in the care plan, which the staff used to understand their tasks, the resident's need for supervision when the residents walking was unsteady. The facility could not anticipate when incidents of unsteadiness would occur, as the resident was impulsive.

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 fall reports, incident reports, resident medical records, policies, and procedures related to service plans, modification of service plans, falls, assessments, and maltreatment of vulnerable adults. Also, the investigator observed resident/staff interaction on the assisted living and memory care units.

The resident lived in an assisted living due to diagnoses that included dementia, history of pneumonia, history of urinary tract infections, malnutrition, and atrial fibrillation. The resident received hospice services from an outside provider that included skilled nursing twice weekly. The resident's service plan included minimal assistance with bathing, housekeeping, dressing, laundry, meal reminders, medication administration, and encouragement to drink fluids. The resident's assessment indicated the resident had a history of falls, but was independent with bed mobility and transferring, independent with toileting, and required occasional supervision with walking due to balance issues. The facility reduced the residents' fall risk by ensuring he had a clear path to walk in his apartment, adequate lighting, non-skid shoes, reminders to use a walker, and stand-by assistance when unsteady.

An incident report indicated a staff heard yelling and entered an apartment (not belonging to the resident) and found the resident sitting on the floor with his back up against a wall mirror. The report indicated the owner of the apartment had yelled for help for the resident. The report indicated the staff took vital signs, called the nurse, and then called hospice. The report indicated the staff moved a wheelchair over by the resident, who refused help, and got himself up off the floor and into the wheelchair.

During an interview, the staff stated the resident required staff to have their eyes on the resident because he was very spirited and walked around the facility. The staff stated the resident was independent with grooming, eating, toileting, and getting in and out of bed. The staff stated on the night of the resident's fall, she had been in the resident's apartment to provide his bedtime medications, fixed his bedding, and got him comfortably settled for the night. The staff stated she went to chart the medications and heard yelling from an apartment down the hall. The staff stated when she got there, she saw the resident sitting on the floor of another person's apartment against a wall mirror that was cracked. The staff stated she took vitals and called the nurse, who reminded her to call hospice, so she did. The staff stated the resident said his leg hurt but he would not let staff assist and he got himself up into the wheelchair that was in the room. The staff stated she moved the resident into his bed to wait for the hospice nurse.

During an interview, a facility nurse stated the resident walked around the facility most of the day, and although the facility made a walker available the resident did not use it. The nurse stated staff were able to easily observe the resident due to only five residents living at the facility at that time, and the resident frequently followed staff around the facility. The nurse stated the resident walked into another's apartment, must have become unsteady, and fell on

his bottom. The facility nurse stated the staff checked vital signs and the resident got himself off the floor. The facility nurse stated the hospice nurse came and assessed the resident. The facility nurse stated hospice ordered an x-ray the following day, which revealed a hip fracture.

During an interview, a hospice nurse stated the resident required stand by assistance when he was unsteady, which was unpredictable.

During an interview, a family member stated the resident was independent and active upon admission, but the resident was generally failing. The family member stated the resident attempted to use a walker but could be confused about how to use it. The family member stated the resident was impulsive, would pop up from sitting, and would think he had to go somewhere. The family member stated the facility did they best they could with the resident. The family member stated the facility gave the resident the necessary attention and care.

The resident did not have surgery for the fracture and passed away about ten days later.

In conclusion, 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.

Vulnerable Adult interviewed: No, the resident passed away.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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 03/29/2023

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 March 29, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL389838879C/#HL389835164M. No correction orders are issued.	0 000		