Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL396781182M
Compliance #: HL396788516C

Date Concluded: June 26, 2024

Name, Address, and County of Licensee Investigated:

Spirit Care Homes
3727 Shady Oak Road
Minnetonka, MN 55305
Hennepin County

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

Evaluator's Name: Michele Larson, 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 alleged perpetrator (AP), facility staff, neglected the resident when they failed to follow the resident's plan of care when the AP released the resident's gait belt when walking the resident. The resident fell and fractured his spine.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP was following the resident's plan of care and facility policies and procedures at the time of the resident's fall. The AP briefly let go of the resident's gait belt during ambulation and instructed the resident to wait for her. The resident continued to walk and fell resulting in a spinal fracture. The incident was an accident which was sudden, unforeseen, and unexpected.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted licensed health professionals. The resident's family member was interviewed. The investigation included review of the resident

record, hospital records, home health record, in-house provider's record, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility with dementia care. The resident's diagnoses included Alzheimer's disease with a history of falls with fractures. The resident's care plan indicated the resident required staff assistance of one using a gait belt and four-wheeled walker when he walked. The resident chose to sleep in his reclining lift chair. The resident had an emergency call pendant he wore on his wrist but did not know how to use it. The resident was oriented to person and place.

The resident's record indicated the resident had four falls during approximately two months at the facility. Three of the falls occurred when the resident attempted to transfer out of the recliner without staff assistance.

An incident report indicated early one morning; the AP was getting the resident ready for the day. The AP instructed the resident to not start walking without her as she momentarily let go of his gait belt to grab trash off his bed. The resident ignored the AP and started to walk then fell backwards, landing on his butt and back. The AP obtained vital signs, performed range-of-motion, checked for injuries, and called the RN. The AP and another staff member got the resident off the floor. The resident initially denied pain and said he felt fine, but later complained of neck and shoulder pain. The registered nurse assessed the resident when she arrived at the facility and called 911 to have the resident transported to the emergency room for an evaluation.

The hospital record indicated the resident was diagnosed with a pathological compression fracture (not caused by force or impact but an underlying disease) in the spinal thoracic (middle back) area (T10). The resident was fitted with a back brace and seven days later discharged to another facility that provided a higher level of care.

During an interview a staff member stated the resident was very impulsive and stubborn, stating, "he wanted to go when he wanted to go, and he wouldn't listen to anybody else." The staff member stated staff always used a gait belt when they walked the resident.

During an interview, the registered nurse stated the resident had a history of falls at his prior facility. The registered nurse stated most falls occurred in his apartment when the resident attempted to get out of his recliner without requesting assistance stating, "his mind said yes, but his body said no." The registered nurse stated, following the fall, the AP was educated to always focus on the resident during ambulation avoiding distractions.

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

"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. Unable to interview due to Alzheimer's disease.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP initially agreed to be interviewed but then declined when the investigator called her.

Action taken by facility:
The facility sent the resident to the hospital for further evaluation. Facility staff instructed the AP to focus on the resident during ambulation and avoid distractions.

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
	39678	A. BUILDING: _____ B. WING _____	C 05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPIRIT CARE HOMES LLC	3727 SHADY OAK ROAD MINNETONKA, MN 55305

(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 20, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL396788516C/#HL396781182M. No correction orders are issued.	0 000		