Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL399593763M
Compliance #: HL399594210C

Date Concluded: September 12, 2024

Name, Address, and County of Licensee Investigated:
Bismol Home Care LLC
5542 Unity Avenue North
Crystal, Minnesota 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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 abused the resident when the facility took away his electric wheelchair which inhibited his mobility and made him unable to come and go as desired.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. During a period of delirium and noncompliance with healthcare recommendations, the providers and family made the decision to remove the electric wheelchair from the resident. The resident did get his electric wheelchair back.

The investigator conducted interviews with facility staff members, including nursing staff. The investigator contacted family. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's electric wheelchair in his apartment.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, paralysis of the lower body, and pressure injuries. The resident's service plan included assistance with transfers, incontinence care, and wound care. The resident's assessment indicated the resident used an electric wheelchair independently but needed help using a manual wheelchair and transferred using a mechanical lift.

The resident's medical record included a progress note indicating the resident left the facility in his electric wheelchair one evening.

The resident's hospital record indicated the resident had been found unresponsive in an unknown apartment building, bleeding from his foot the next morning. The resident spent about one month in the hospital. Diagnoses included an altered mental state, low oxygen level, infection in the bone and blood, a pressure injury, and nonadherence to medical treatment. Psychiatry determined the resident had acute confusion and identified the resident as not decisional. Hospital staff, multiple family members, and one facility staff member held a care conference to discuss concerns about the resident's compliance. The resident left the facility on his electric wheelchair for hours to days at a time and willingly sat in feces. Hospital staff informed them the resident must have frequent repositioning, incontinence cares and wound cares, incompatible with his electric wheelchair use. The family requested to remove the electric wheelchair for the time being and the resident not have access to independent use of a manual wheelchair. Given his confusion, the resident could not be allowed to leave the facility unattended.

Various progress notes over the following weeks after returning to the facility indicated the resident progressed from being confused and drowsy to alert. The notes indicated staff completed incontinence care, wound care, and repositioning.

Approximately six weeks after returning from the hospital, the resident had an appointment with a provider at a wound care clinic. The provider's visit note indicated they recommended being in a chair for a maximum of one hour at a time, three times daily. The visit note indicated the resident had an increased risk for worsening wounds and a high likelihood of death if he continued his current path.

During an interview, a nurse stated the facility did not make the decision to remove the resident's wheelchair. When the resident had been in the hospital, family and the hospital staff held a care conference because he appeared confused and could not always use the electric wheelchair. The resident seemed happy facility staff assisted him to go outside in the manual wheelchair. With the manual wheelchair, the resident could still leave for appointments and go other places like the grocery store.

During an interview, the resident stated he did get his electric wheelchair back.

During an interview, the resident's family member stated the facility did not make the decision to take away the resident's electric wheelchair. The resident had been delirious and unable to make decisions. At one point, the resident did not know who they were. Family members held a meeting with hospital staff, and they came up with the decision to remove the electric wheelchair. The resident needed to stay in bed due to an infection in his bone and in his blood, as well as a pressure injury on his bottom and golf-ball sized hole in his hip. The facility had previously been following the resident's requests to transfer into the electric wheelchair, and then he would leave the facility, staying in his wheelchair for hours. While he did not have access to the electric wheelchair, the facility provided a manual wheelchair, so he could still go outside and do the things he wanted to do. The resident recently got his wheelchair back, after the infection cleared. The family member stated the facility staff really cared for him and even visited him in the hospital.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided a manual wheelchair for the resident to use while he did not have his electric wheelchair. The facility also assisted him to go outside and complete errands as desired while utilizing the manual wheelchair. The facility returned the resident's electric wheelchair immediately after being informed he could have it back.

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
	39959	A. BUILDING: _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIMSOL HOME CARE LLC	5542 UNITY AVENUE NORTH CRYSTAL, MN 55429

(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 22, 2024, the Minnesota Department of Health initiated an investigation of complaint HL399594210C/HL399593763M. No correction orders are issued.	0 000		