Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302362084M
Compliance #: HL302363733C

Date Concluded: December 23, 2022

Name, Address, and County of Licensee Investigated:
Summerwood of Plymouth
16205 36th Avenue North
Plymouth, MN 55446
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP), who worked as a unlicensed personnel (ULP) providing cares, neglected a resident when she attempted to transfer the resident off the floor with a Hoyer lift (a total assist lift) by herself without notifying the nurse.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. While the resident did fall while the AP was present and the AP attempted to transfer the resident alone with the Hoyer lift, she was unable to complete the inappropriate transfer.

The investigator conducted interviews with the resident, facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included a review of the resident's records, the AP personnel record, the facility's policies, and procedures, and the resident's external medical record. The

investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident lived in an assisted living facility. The resident's diagnosis included chronic left pelvic fractures. The resident's service plan included one person transfer with a stand-assist lift for mobility, medication administration, and housekeeping.

One day the AP intended to give the resident a shower when he fell during the transfer. Initially, the AP attempted to get the resident up before notifying the nurse using a Hoyer lift but could not, so she requested assistance from a co-worker who suggested they call the nurse.

The resident's progress notes indicated the resident complained of left hip pain during the nurse assessment, so the facility sent the resident to the hospital for evaluation.

The resident's hospital records indicated the resident had no fracture but did have increased pain after the fall. The same documents indicate he transferred to a transitional care unit where he received physical therapy before returning to the facility.

During an interview, the ULP stated the AP called her for help, so she went to the resident's room and saw the resident was on the Hoyer lift. The ULP stated she told the AP they needed to call the nurse before transferring the resident. When the nurse arrived, she assessed the resident and sent him to the hospital. The ULP stated the resident usually transferred with a one-person assisted using the stand-assist lift

During an interview, the clinical administrator (CA) stated the AP told her it was a controlled fall. The CA stated the nurse found a bruise on the resident's left hip, so the CA questioned the AP again about what happened. The CA stated the AP said the resident fell during the shower transfer and the AP went to get a Hoyer lift instead of notifying the nurse. However, the resident's bathroom was too small to use the Hoyer lift, so the AP called the ULP for help. The CA confirmed it is facility policy to have two people present for a Hoyer lift transfer and the AP should have call the nurse right away. The CA stated she personally asked the AP to demonstrate how to use the Hoyer lift and taught her how to use it. The CA suspended the AP until she could complete additional education, however the AP did not return to work at the facility.

During an interview, the resident did not recall anything about the incident. He had no concerns with the care he received at the facility.

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: No, the attempts to interview the AP were not successful

Action taken by facility:
The facility initiated an internal investigation and placed the AP on administrative leave. The AP did not return to work at the facility.

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
	30236	A. BUILDING: _____ B. WING _____	C 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF PLYMOUTH	16205 36TH AVENUE NORTH PLYMOUTH, MN 55446

(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 Initial comments On November 22, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL302362084M/HL302363733C. No correction orders are issued.	0 000		