Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358148745M
Compliance #: HL358146264C

Date Concluded: November 28, 2023

Name, Address, and County of Licensee Investigated:
Hands At the Cross Care Home
11010 Sweetwater Path
Woodbury, MN 55129
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, 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 a resident when they restrained the resident using a specialized wheelchair with ankle straps, a lap tray, and a chest strap; as well as a hospital type bed with crib style railings. The facility had no physician orders, no indications for use, and no direction regarding duration of use and/or removal of the restraint. The resident was unable to remove the restraint(s).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The facility had provider orders for the use of the specialized wheelchair with a lap tray, seat belt, foot straps, and a crib style bed with side rails to keep the resident safe. The resident's lap tray, seat belt, and foot straps were removed several times a day.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of resident's record including provider orders, staff documentation, and policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral palsy (a group of disorders affecting movement, balance, and posture), choreoathetosis (a type of cerebral palsy causing irregular and rapid contractions of muscles, including those of the face, extremities, and toes and fingers with slow, writhing movements of the extremities), a history of numerous fractures of the lower extremities, and profound intellectual disability. The resident was non-verbal and communicated through gestures and required others to anticipate her needs. The resident required a tracheostomy (an opening in the windpipe for breathing) and a gastrostomy tube (opening into the stomach through the abdominal wall) for liquid feedings four times a day.

The resident's service plan included assistance from two to three staff with all activities of daily living including transfers with a sling mechanical lift, repositioning every two hours, and as needed when in the wheelchair and when in bed, one staff to ensure the integrity of the tracheostomy and gastrostomy tubes during transfers and repositioning, and one-to-one nursing supervision for safety. The resident's nursing assessments indicated the resident was unable to control body movements and kicked her legs and swung her arms aggressively. The assessment indicated the resident was a high risk for falls.

The investigator observed staff transfer the resident to the wheelchair. The wheelchair had a lap tray, a seatbelt, and foot pedal straps that went across the top of the resident's foot. The back of the foot pedals were padded to prevent injury. There were no shoulder straps on this wheelchair. The resident was able to move her arms and legs but was unable to kick her foot outward. Staff were able to tip the resident's wheelchair backward to offload (reduce weight) to the resident's buttocks.

The resident's provider orders indicated the specialized wheelchair with the seatbelt, lap tray, and foot straps, were used for the resident's movement disorder and cerebral palsy and used throughout the day for safety purposes and home mobility. The resident required a crib bed rails up when the resident was in bed for resident safety and providing cares in the resident's home.

A provider's note in the resident's record indicated the resident was under the care of the provider for choreoathetotic movements related to a brain malformation. For that reason, the resident needed to have her feet in foot straps on her wheelchair. The provider stated he considered the foot straps on the wheelchair a safety measure to prevent secondary injury from involuntary movements that could not be controlled with other medical interventions.

The resident's record indicated the resident was released from her safety straps for activity assistance twice a day, incontinence care and repositioning every two hours and as needed, and

for manual leg, hip, and ankle exercises daily. The resident required one-to-one nursing supervision for the resident's safety.

During an interview, the nurse stated the resident required direct care nursing twenty-four hours a day for the care of her tracheostomy and feeding tube. The nurse stated the resident was repositioned every two hours, and when the chair was reclined the foot straps were removed. The nurse stated the resident's wheelchair did not have a chest strap.

During an interview, a family member stated the hospital customized the wheelchair for the resident and she had the wheelchair for three years. The family member stated she did not consider the safety straps to be restraints. The resident had broken her foot twice from banging her foot on the wheelchair, therefore, the straps were needed to keep her safe. The crib was called a sleep safe bed and designed with padded rails to protect the resident from harm. The family member stated the staff were vigilant with the care of the resident and were doing a great job of keeping the resident safe.

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:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, resident was nonverbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Prior to the investigation, provider orders were obtained for sleep safe bed and wheelchair with foot safety straps and lap tray.

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
	35814	A. BUILDING: _____ B. WING _____	C 10/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS AT THE CROSS CARE HOME	11010 SWEETWATER PATH WOODBURY, MN 55129

(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 October 9, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL358146264C/#HL358148745M. No correction orders are issued.	0 000		