Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL382062301M
Compliance #: HL382064049C

Date Concluded: September 29, 2022

Name, Address, and County of Licensee Investigated:
Family Tree Care Homes
3233 Richmond Avenue
Shoreview, MN 55126
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN
Special Investigator
Angela Vatalaro, 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) neglected the resident when they failed to follow the care plan which resulted in a fall and a hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The AP made an error in therapeutic conduct when the AP did not transfer the resident per the plan of care. Subsequently, the resident fell, transferred to the hospital, and passed away. The error was an isolated incident, and the AP did not have a pattern of not following the care plan. The extent to which the resident's existing health condition of spinal stenosis and brittle bones contributed to the outcome could not be determined.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member, medical doctor, and AP. The investigation included review of resident's medical record, facility's internal investigation, death record, facility policies included delegation of nursing tasks, resident emergencies 911 calls, service plans, reviewing incidents, supervision of personnel, and maltreatment. The AP's personnel file was reviewed. Also, the investigator observed transfers of other residents at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included stroke, loss of strength and weakness of the left side, and arthritis of the spine. The resident's service plan included assistance with transfers using a stand lift (a device used to assist with standing), and toileting. The resident's care plan included step by step instructions on how to transfer the resident from the bed to wheelchair using the stand lift. The resident's assessment indicated the resident was oriented but forgetful and used a wheelchair for mobility.

The facility internal investigation indicated the AP performed a transfer that was not in accordance with the training and the resident's care plan. The resident's instructions for transfers indicated the resident transferred from bed to wheelchair at 90-degree pivot transfer with a stand lift. A written statement from the AP indicated the resident stood up with the stand lift and she attempted to pull the machine while the resident was standing down the hallway to the bathroom. As the AP began to transfer the resident down the hallway, the resident fell backwards and hit his head and back on the floor. The AP called the nurse, then the nurse called 911. The paramedics arrived and transferred the resident to the hospital. Later in the day, leadership received a phone that the resident had passed away.

The resident's death record indicated the cause of death was complications of vertebral fractures and fall to the floor.

During an interview, unlicensed personnel (ULP) stated the resident required a stand lift for transfers. The resident's wheelchair needed to be next to the foot of the bed. Then the resident would be in a seated position on the edge of the bed, the resident would put his feet on the foot platform of the machine. While the ULP stood to the left side of the resident, the resident would pull himself into a standing position. Once the resident was in a standing position, the ULP moved the machine 90 degrees, while having one hand on the resident's lower back and have the resident sit into the wheelchair. Once the resident was in the wheelchair, the ULP brought the resident down the hallway to the larger main bathroom. The day the resident fell, the ULP had just arrived at the facility shortly after the incident. The AP told the ULP "I don't know what I was thinking." The AP told the ULP she got the resident out of bed using the stand lift machine, started to pull the resident towards the hallway. When they got to the doorway of the bedroom, the resident fell backwards into the room. The ULP stated prior to working with the resident, leadership performed training and demonstrated how the resident transferred.

During an interview, leadership stated the resident had no cognitive impairments, and had left sided weakness. When the resident admitted to the facility, the discharging facility sent orders for the resident to use a hydraulic stand-up for transfers. The stand-up machine used a sling that goes behind the residents back and under the arms. The resident's left arm contracted into his body. When the sling was applied it caused pain to the resident during transfers. The nurse and leadership assessed with the resident and provided written step by step instructions on how to transfer the resident from bed to wheelchair. Leadership stated the fall occurred when the AP went to get the resident out of bed. The AP got the resident into a standing position, and began to pull the machine towards the hallway, down to the large bathroom. The AP did not transfer the resident into the wheelchair per written instructions. Leadership stated the resident had no other falls at the facility. There were no concerns with how the AP transferred or cared for the residents. The resident did not have a history of falls at the facility. The AP received training which included a return demonstration on how to transfer the resident. The AP read the written instructions and received verbal communication prior to the AP working with the resident.

During an interview, the nurse stated leadership taught all staff on how to transfer the resident and provided written instructions because the resident had a special transfer. The AP was trained on the resident's special transfer. The nurse stated when the resident admitted to the facility, they attempted to use a stand lift with a sling, but the resident expressed pain with the sling under his left arm. The resident was able to bear weight and pull himself up. The nurse had no concerns with the AP providing care or transferring the residents.

During an interview, the medical doctor stated the resident could not walk and had left sided effectiveness due to a stroke. The resident was alert and able to make his needs known. The resident had a condition where the spine started to fuse together. Because the resident's spine had a condition, it was hard for the resident to stand up straight and would lean forward. During a fall, someone with a normal spine would not receive any fractures, but in the resident's case, would suffer fractures easily because of the spine. The medical doctor compared a normal spine as a wet spaghetti noodle being dropped on the floor, most likely nothing would happen, but drop a glass cup on the floor, and it would break.

During an interview, the family member stated they had no concerns with the resident's care at the facility. The resident fell because the AP used an incorrect transfer, the resident lost his grip and fell. The resident used his right arm to hold himself up. The resident had a spine condition that would not allow him to walk straight up, bones were brittle, stiff, and had pain. The family member stated, "any fall would have been detrimental to him."

During an interview, the AP stated the resident wanted to get ready for the day. The resident sat on the edge of the bed, she had placed his feet on the foot pedal and the resident stood himself up with the stand lift. She was on the opposite side in front of the resident, started to pull the stand lift out of the resident's room, down the hallway to the bathroom and the resident fell onto his back. She immediately checked on the resident who stated he was having

neck pain 5 out of 10. She called the nurse, who alerted 911. The AP obtained a set of vital signs and got a pillow for the resident's head as he laid on his back. She attempted to move the resident as little as she could, the resident rolled himself onto his side. The AP stated she received training from leadership by leadership demonstrating how to transfer the resident. The AP stated after leadership demonstrated the transfer, she felt good but was not comfortable using the stand lift without the safety strap. The AP stated it was not clear in the training that the resident was to go from bed to wheelchair and then to the bathroom. The AP stated she thought it was okay to bring the resident to the bathroom from the bed using the stand lift.

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
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
After the resident fell, the AP contacted the nurse, and called 911. The resident transported to the hospital. The facility completed an internal investigation. After the incident, the facility provided re-education to staff on following resident's care plans. Leadership and nursing increased their audits of residents' care plans to ensure staff had acknowledged they read and understood residents care plans. The AP is no longer employed by 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
	38206	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY TREE CARE HOMES LLC	3233 RICHMOND AVENUE SHOREVIEW, MN 55126

(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 September 8, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL382064049C/ #HL382062301M. No correction orders are issued.	0 000		