Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL204276241M
Compliance #: HL204279281C

Date Concluded: February 5, 2025

Name, Address, and County of Licensee Investigated:
Parkwood Shores Assisted Living Facility
3633 Park Center Blvd 103
St. Louis Park, MN 55416
Hennepin County

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

Evaluator's Name: Lori Pokela R.N.
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) abused the resident, when she transferred the resident incorrectly following a recent right arm fracture surgery and the resident sustained another fracture of the right arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Documentation reviewed provided no evidence that abuse occurred. Staff reported the resident's complaints of pain to the nurse and the nurse assessed and monitored the resident. When complaints of pain continued, the physician was contacted, and an x-ray was ordered. Although it was reported that staff improperly transferred the resident, no specific staff member was identified.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's hospital case manager and the resident's provider. The investigation included review of the resident

record(s), death record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed the facility environment and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included breast cancer with metastasis to the bone, osteoporosis, history of femur, right pelvic and right shoulder fractures. The resident's service plan at the time of the incident included assistance with showers, medication management, and mobility escorts. The resident's assessment at the time of the incident indicated the resident was disoriented with memory impairment. The assessment also indicted the resident required staff assistance with activities of daily living, (ADLs), including dressing, grooming, and toileting. The resident received staff assistance for getting in and out of bed and for transfers. The resident utilized wheeled walker for mobility and a manual wheelchair for physician visits. The resident's assessment indicated the resident had balance issues when standing and walking.

A facility investigation indicted the resident complained of increased right arm pain approximately thirty-nine days post-surgery following repair of a right arm fracture.

Internal investigation documentation indicated several staff had assisted the resident with transfers prior to the onset of the new complaints of pain. When staff alerted nurse management of the resident's pain, the nurse assessed the resident's pain and initially administered previously ordered pain interventions. Later that evening, the resident's family contacted the facility about the resident's complaints of pain. The next day when the resident's complaints of pain continued, a triage nurse was contacted who directed staff to elevate the arm, administer scheduled pain medications, and to call back if complaints of pain continued. When the resident's complaints of pain continued, the provider was contacted and an x-ray of the arm was ordered. The resident's x-ray revealed another fracture to her right arm then the resident's family transported the resident to the hospital.

The resident admitted to the hospital and another surgery to repair the right arm fracture was completed. The resident transferred to a transitional care unit for three days prior to returning to the facility.

During an interview, the resident's family member stated when visiting the resident on a Friday, the resident was found to by laying on her couch unable to get up, stating that her arm hurt. During the visit, the resident reported someone lifted her incorrectly. The resident was unable to give a description of the staff member that transferred her incorrectly. At the time of the visit the resident was not using her walker and family observed staff on several occasions to transfer the resident to a wheelchair with staff assistance and without a transfer belt.

During an interview, an unlicensed staff who worked on Friday, stated she approached the resident when she was laying on the couch and did not want to go to BINGO, which she normally attended. The resident was observed to be holding her arm and the unlicensed

personnel reported the pain to nursing staff. The unlicensed personnel did not recall receiving a report concerning the resident's arm prior to the start of her shift.

During an interview, a management nurse indicated she was informed on Friday, by the administrative nurse and unlicensed personnel that the resident was having pain in her right arm. The management nurse assessed the resident and instructed an unlicensed staff to administer an as needed pain gel medication to the resident's right arm. After the pain gel was administered, unlicensed personnel informed the nurse that the resident's arm was feeling better.

During an interview, a second family member of the resident stated when visiting the resident on Tuesday, the resident reported her arm immediately started hurting after a staff member lifted her out of her bed.

During an interview, the resident's provider stated the fracture was likely a result of the transfers and the resident's diagnoses.

During an interview, an administrative nurse stated that the resident's family member reported the resident to be doing well in therapy the Thursday before the complaints of pain started. The administrative nurse stated facility staff should have completed a follow-up call to a nurse on both Saturday and Sunday if the resident had continued pain. A facility investigation was initiated to investigate the incident and the evening shift staff member demonstrated how he transferred the resident using her walker and held her right arm. The administrative nurse assigned proper transfer training to the staff member.

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.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed a facility investigation and incident report.
The facility completed re-training of proper transfers.

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
	20427	A. BUILDING: _____ B. WING _____	C 12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	3633 PARK CENTER BOULEVARD SAINT LOUIS PARK, MN 55416

(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 December 17, 2024, through December 27, 2024, the Minnesota Department of Health conducted a complaint investigation HL204279281C/HL204276241M at the above provider. No correction orders are issued.	0 000		