Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL300813710M
Compliance #: HL300816154C

Date Concluded: March 7, 2023

Name, Address, and County of Licensee Investigated:
Oak Hills Assisted Living
1971 NE 1st Ave
Grand Rapids, MN 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Not Substantiated

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 resident was neglected when alleged perpetrators (AP), AP #1 and AP #2, two facility staff, transferred the resident using a full body mechanical Hoyer lift and failed to open the legs of the lift during the transfer. As a result, the lift tipped over causing the resident to fall and sustain fractured ribs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. AP #1 and AP #2 were transferring the resident using a full body mechanical lift. The legs of the lift were not opened all the way prior to attempting to move the resident in the lift. The mechanical lift began to tip, and the resident fell. This was an isolated, unforeseen incident, both APs were trained in operating a mechanical lift and had no record of past concerns regarding safely

operating a mechanical lift. The resident returned to her normal baseline following the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of Hoyer lift maintenance records, staff schedules, staff training, AP personnel files/disciplinary action, facility policies and procedures for safe patient handling, resident facility and outside medical records (hospital and emergency), and facility incident reports incident reports. The investigator observed staff transferring a resident using a full body mechanical Hoyer lift.

The resident resided in an assisted living facility with diagnoses including right sided hemiparesis (muscle weakness or partial paralysis on one side of the body). The resident's assessment indicated she was non ambulatory and required two staff assist using a mechanical Hoyer lift for transfers.

A progress note indicated AP #1 and AP #2 immediately reported the incident to leadership staff. The note indicated when the resident was being transferred out of bed the Hoyer lift tipped, and the resident fell to the ground from waist height. The note indicated staff were unable to catch the resident or stop the Hoyer from tipping. The note indicated the resident was transferred to the emergency department for evaluation. About two weeks later, another progress note indicated the resident had recovered from her injury and returned to her baseline.

The residents outside medical record indicated the resident had sustained two nondisplaced fractured ribs, with no other acute findings noted.

When interviewed AP #1 stated she had been trained and felt comfortable operating the Hoyer lift. AP #1 stated she initially had the legs of the Hoyer closed to avoid running over the bed power cord, and when she pulled the Hoyer out from under the bed, the lift began to tip, and the resident fell.

When interviewed AP #2 stated she was assisting AP #1 to transfer the resident on the opposite side of the bed and could not see that the Hoyer legs were closed. AP #2 stated the lift began to tip and the resident started to fall. AP #2 stated she attempted to intervene but was unable to stop the lift from tipping and the resident from falling.

A review of AP #1, and AP #2 personnel files indicated both staff were properly trained to operate the Hoyer lift and had no prior incidents or disciplinary actions.

When interviewed the resident stated the Hoyer tipped to the left and she fell on the carpet. The resident stated her ribs healed, and she recovered from the incident.

The investigator observed staff transfer a resident using a Hoyer lift with no safety concerns noted. When interviewed multiple staff stated they had received Hoyer lift training before and after the incident and felt competent to operate the equipment safely.

When interviewed facility leadership stated after the incident the bed power cord was fastened to the frame of the bed and retraining in Hoyer lift operation was completed with all staff to prevent recurrence.

When interviewed another resident stated she felt safe when staff transferred her using the full body mechanical Hoyer lift and had no concerns regarding staff knowledge of using the lift.

The resident's family member stated the incident was an accident, and the facility had done extensive training with staff on use of the Hoyer lift to prevent recurrence.

In conclusion, neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility educated and trained staff in use and operation of a mechanical Hoyer lift use prior to the incident. Staff immediately reported the incident, the resident was transferred to the ED for evaluation and treatment. The facility reported the incident to the lead investigative agency, investigated the incident, interviewed the resident and staff involved, provided all staff re-education, and ensured the equipment was safe to use to prevent recurrence.

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
	30081	A. BUILDING: _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL ASSISTED LIVING	1971 1ST AVENUE NE GRAND RAPIDS, MN 55744

(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 February 7, 2023, the Minnesota Department of Health initiated an investigation of complaint HL300813710M, and HL300816154C . No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	