Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312218224M
Compliance #: HL312215334C

Date Concluded: February 7, 2024

Name, Address, and County of Licensee Investigated:
Carefree Cottages of Maplewood
1801 Gervais Ave
Maplewood, MN 55109
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN
Special Investigator

Finding: Inconclusive

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) neglected a resident when the AP was pushing the resident back to her room with the resident seated on her four wheeled walker. While seated on the walker, the resident fell off the walker backwards.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Conflicting information was provided by the AP and the facility. Facility staff were aware the resident had a history of using the walker inappropriately by self-propelling seated on the walker. The AP denied pushing the resident when the resident was seated on the four wheeled walker.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator completed interviews with the resident's family member and the AP. The investigation included review of the resident's medical record,

facility investigation, staff schedules, hospital records and facility policies. Also, the investigator made an unannounced facility visit.

The resident resided in an assisted living facility. The resident's diagnoses included intellectual disability, diabetes, and peripheral neuropathy (condition often causes weakness, numbness, and pain, usually in the hands and feet). The resident's service plan included assistance with transfers as needed. The resident's assessment indicated the resident was alert and oriented. The resident's care plan indicated the resident required occasional stand by assistance when ambulating using a walker and had an electric wheelchair for mobility and required occasional staff assistance with escorts. The resident was at risk for falls.

An incident report indicated one morning; the resident was brought to the nurse's station by staff seated on the seat of the resident's four wheeled walker. The AP was directed by the nurse to bring the resident back to her room. With the resident seated on the walker, the walker caught a raised area on the floor in a doorway and the resident fell on her back onto the floor. The AP yelled for help and additional staff came to assist the resident. The report indicated the resident had a history of scooting herself when seated on her walker which was unsafe and further resident education was needed. Facility staff arranged for the resident to be evaluated at a hospital.

Hospital records indicated the resident sustained a lumbar (lower back) fracture with non-surgical treatment and pain medication. The resident returned to the facility the same day after being able to ambulate independently with the walker.

During an interview, an activity staff stated prior to this incident, the resident was in the nurse's station after returning from the hospital. The resident was sitting on her four wheeled walker and was pushed into the nurse's office by a staff member. The AP was in the nurse's office at the same time and asked by the nurse to assist the resident back to her room. The activity staff stated the AP pushed the resident out of the nurse's office while the resident was seated on her four wheeled walker. Shortly after the AP and the resident left the nurse's office, the AP yelled for help. The activity staff stated she came out of the nurse's office and saw the resident on the floor.

During an interview, a nurse stated the day of the incident the resident came into the nurse's office and asked for help in her room. The nurse stated she asked the AP to bring the resident back to her room and left the nurse's office. After 15 to 20 minutes, the nurse stated she returned to the nurse's office and saw the resident on the floor in the hallway, by the fire door. The activity staff and the AP were standing over the resident. The nurse stated the AP told her she was pushing the resident back to her room when the resident fell off the four wheeled walker. The nurse said the resident required daily reminders not to use the walker as a wheelchair. The nurse arranged for the resident to be evaluated at a hospital.

During an interview, facility leadership stated the resident used the four wheeled walker as a wheelchair by sitting on the seat of the walker and used her feet to wheel herself. Leadership stated staff provided the resident education to use the walker only when walking, however, the resident continued to use the walker incorrectly. Leadership stated the AP reported she was pushing the resident back to her room with the resident seated on her four wheeled walker. The wheels of the resident's walker hit a raised area on the floor and the resident fell off the walker.

During an interview, the AP stated she saw another staff member push the resident into the nurse's office with the resident seated on the seat of the four wheeled walker. The AP stated because this was her first day at the facility, the AP was in the nurse's station reviewing the resident's care plan. The AP stated the nurse asked the AP to assist the resident back to her room. The AP stated the resident appeared impatient and began self-propelling herself backwards seated on the walker using her feet. The AP stated she followed the resident and placed her right hand on the resident's right shoulder. The AP stated she was not pushing the resident on the four wheeled walker, the resident propelled herself. The AP stated the resident did not slow down at the entrance of a doorway and the wheels of the resident's walker hit a raised area in the floor and the resident fell backwards off her walker.

During an interview, the family member stated the resident did not use the walker correctly. The resident would sit on the four wheeled walker and propel herself.

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: No. Attempts made were unsuccessful.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed vital signs, called 911 and had the resident sent to the hospital. The AP was no longer employed 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
	31221	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHATEAU	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

(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 November 9, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL312218224M/#HL312215334C. No correction orders are issued.	0 000		