Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326498965M **Date Concluded:** December 5, 2023
Compliance #: HL326496489C

Name, Address, and County of Licensee Investigated:
Rivers Edge Assisted Living
11 MN Ave South
Aitkin, MN 56431
Aitkin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Julie Serbus, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 neglected the resident when the facility used an EZ stand (stand-assist lift) without securing the sling causing the resident to fall during a transfer. The facility failed to document the fall nor interventions to prevent future falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident fell while the EZ stand was in place when the sling became detached, but this fall was not recorded in the resident's medical record. The sling became detached because of a missing safety latch and, while the specific EZ stand was taken out of service, the facility did not have a system in place to maintain equipment EZ stand(s) which continued to be in use. Additionally, the investigation found the facility continued to use an undersized sling during transfers which caused the resident discomfort approximately eight months after his admission to the facility. Th EZ stand owned and used by the facility was not approved by the EZ stand manufacturer for use of the resident's weight.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's facility record, nursing assessments, service plans, and progress notes. Also, the investigator toured the facility and observed staff transfer the resident with EZ Stand from bed to chair and chair to bed.

The resident resided in an assisted living facility. The resident's diagnoses included morbid obesity, depression, diabetes, and congestive heart failure. The resident's admission assessment indicated the resident required assistance of an EZ Stand for transfers, full assistance with wheelchair mobility, and some assistance to sit up in bed. The assessment did not indicate number of staff members for each of the tasks.

Fall(s) using EZ stand

The facility fall reported indicated the resident reported undocumented falls, which were determined to have occurred approximately six months, earlier about two weeks after the resident admitted to the facility. The same document indicated unlicensed caregivers witnessed the falls and could confirmed they occurred. During the first of the two falls, report indicated an unlicensed caregiver was transferring the resident with the EZ stand from the bed to wheelchair when the sling slipped from the machine and resident fell to the floor.

The same document indicated at the time of the first fall nurse #1 said she assessed the resident at the time, but he denied being hurt. The incident report indicated she said she took the EZ stand out of service because it was missing a safety latch on the side that the sling released.

The same document indicated the root cause analysis of the first fall included equipment not in good working order, unlicensed caregiver using lift with one person, and the weight of the resident exceeded the limit for the EZ stand in use.

The manufacturers literature for the EZ Way Sit to Stand (EZ Stand) indicated it was durable medical equipment used to assist a person to transfer by helping the person from a sitting to standing position. A padded harness goes around the back of the resident, then under their arms, and is hooked onto a bar on the lift where a wire clip keeps the harness attached. The wire clip is a safety tab designed to keep the harness securely attached to the stand.
Once the person is secured in the harness, the operator presses a button to control the EZ stand to assist the person to stand up. The person must be able to bear weight and grasp onto the handles to use this type of transfer device.

A review of the resident's medical record indicated there was no documentation of the resident's fall at the time it occurred until the resident reported it several months later.

The resident's hospital records indicated the resident transferred with assist of two staff with an EZ stand while in the hospital.

The resident's admission assessment indicated the resident required a EZ Stand but the same document did not specify how many staff members were to perform the transfer.

The resident's assessment completed approximately one week after the undocumented fall included the same information as the previous assessment regarding transfers and once again did not specify the number of staff members required for transfer. The same document included actions to address fall risk which included a pendant to ask for assistance, wheelchair for mobility, and mechanical lift [EZ stand] for transferring but did not include clarification of the number of staff members required for transfer.

A review of the facility's month service chart indicated no directions were listed for the resident's transfers until after the resident had been at the facility for approximately six months. At that time, the directions to unlicensed caregivers included use of the EZ stand with assistance of two people.

The facility did not provide any maintenance records or logs for the EZ stand.

EZ Stand Sling

During the onsite visit conducted for this maltreatment investigation, the investigator observed staff transferring resident with an EZ Stand and noticed the caregivers needed to pull the resident forward, with more than minimal handling, when attaching the harness to the EZ stand which caused the resident discomfort. The investigator observed the size of the sling in use for the resident's transfer.

The manufacturers literature for the EZ Way Sit to Stand (EZ Stand) indicated it was durable medical equipment used to assist a person to transfer by helping the person from a sitting to standing position. This same literature indicated harnesses are designed to be applied or removed with a minimum amount of handling of the patient. As patients vary in size, shape, and weight, these conditions must be taken into consideration when deciding the size of the EZ Way harness as there are a variety of sizes available.

The resident's hospital records indicated the resident's weight was communicated to the facility prior to the resident's admission to the facility.

The resident's scheduled services indicated weights were to be obtained and recorded twice a week.

A review of the resident's medical record found the resident's weight was not recorded by the facility on the day of admission. The resident's first recorded weight was not until he had been residing at the facility for two weeks. Initially, these results indicated the resident's weight fell within the recommended limits of the facility's EZ-Stand.

However, the facility only recorded the resident's weight sporadically over the course of the next six months. While the resident's weight was not obtained as planned, a review of the weights that were obtained indicated the resident's weight later exceeded the manufactured recommended limits of the EZ Stand owned by the facility.

Based on observations conducted at the time of the onsite visit for this investigation, the facility continued to use the same EZ-Stand even though the facility had documented resident weights exceeding the manufacturer's recommendations.

Interviews

During an interview, the resident stated during a transfer the strap came off one side of the EZ stand and he dropped down to the floor landing on his tailbone. The resident stated the strap on one side of the lift slipped out of position due to a piece of equipment missing that is used to hold the strap in place. He stated the harness that goes around his back and hooks onto the stand is a size too small for him, causing pinching to his skin.

During an interview, the nurse #2 stated the resident told her about a time he fell while being transferred with the EZ stand several months earlier and landed on his tailbone which caused him pain for a while. She stated there was no documentation of this fall in his medical record, but she was able to confirm the event through interviewing staff members. Nurse #2 confirmed the resident remained care planned as a one person transfer after the fall although the nurse consultant changed it to a two-person assist for transfers with the EZ stand when she learned of the situation. Nurse #2 confirmed she found there was a second fall which occurred with the EZ stand the month after the first fall and there was no documentation regarding that fall either. Both of these falls predated nurse #2 involvement at the facility. Nurse #2 stated she was working to obtain an EZ stand and sling appropriate for the resident's weight and size. She stated the resident required the next size up because the weight alone would not account for his size and the facility was working to on getting the correct sling size at the time of the interview.

During an interview, nurse #1 stated the resident's preadmission was completed over the phone, the hospital provided the resident weight, and the facility could meet his needs. She stated the hospital said he transferred using an EZ stand but did she did not ask the hospital how many staff members were required for the transfer. She stated the facility's policy for using EZ Stands for transfer allowed for one staff member along with the lift. When determining the appropriate sling, nurse #1 stated she used the medium size sling provided by the facility based on recommended weight limits rather than take into consideration the resident's size. Nurse #1 acknowledged the resident's physical size meant he required a larger sling, but she did not order one stating she reached out to the county however never heard back from them. She stated she looked into ordering a sling for the facility, but the sling was expensive, and she did not order it. She stated the owners said that the facility could order the sling within the last month. She stated she used the weight provided by the hospital and not a weight obtained at the facility on admission. She stated she thought the maximum weight for the facility EZ stand

was 450 pounds but had since learned the actual maximum weight is 400 pounds. She also stated she did not realize the resident had gained weight. She stated someone came to look at the equipment but could not recall the date nor was she able to locate a facility maintenance log for the EZ stand in use for the resident's transfer nor who identify who would be responsible for maintenance.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes
Family/Responsible Party interviewed: No, VA is independent with decisions
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility placed the faulty lift in locked storage and used the second lift the facility owned. When the consulting nurse learned of the fall, she investigated the event and filed a MAARC report. Nurse #1 was no longer employed in a nursing role at the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for

possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Aitkin County Attorney
Aitken City Attorney
Aitken Police Department
The Minnesota Board of Nursing
The Board of Executives for Long Terms Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32649	A. BUILDING: _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE ASSISTED LIVING	11 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL326496382C/HL326498805M HL326496489C/HL326498965M On October 16, 2023, through October 18, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 33 residents receiving services under the provider's Comprehensive Assisted Living license No correction orders are issued for HL326496382C/HL326498805M. The following correction order is issuedL326496489C/#HL326498965M, tag identification 2310 and 2360.	0 000	Minnesota Department of Health is documenting the State 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 f	
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure facility services were provided using a service plan subject to accepted health care standards for one of three residents (R2). The facility used an EZ stand (stand assist device) to transfer, which was not maintained according to manufacturer instructions and was missing a safety latch which led to R2 to fall during a transfer. Additionally, the facility failed to use the correct sized sling with the EZ stand which caused the resident discomfort during transfers. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the facility on February 6, 2023, with diagnoses which included morbid obesity, depression, diabetes mellitus type 2, and congestive heart failure. R2's admission assessment dated February 7, 2023, indicated R2 needed adaptive equipment	02310		

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02310	Continued From page 2 for transfer and a wheelchair for mobility. R2's Individual Abuse Prevention Plan (IAPP) dated February 7, 2023, indicated R2 was non-ambulatory and required a wheelchair. An incident reported dated September 28, 2023, at 1:00 p.m., indicated that approximately six months beforehand facility staff member(s) transferred R2 with the EZ stand from bed to wheelchair when the sling slipped from the machine and fell to the floor with R2 landing on his right side. The report indicated the nurse was notified, checked R2 for injuries, and a Hoyer lift was used to transfer resident from floor to bed. This same document indicated the EZ stand was missing a safety latch on the side that had released. Review of facility incident forms and medical records for R2 indicated no documentation had been completed and it was not until September 28, 2023, at 1 p.m. when a incident report was completed for fall from the EZ stand when transferring which occurred approximately the week of February 20, 2023. Review of facility incident forms for R2, indicated no documentation or incident report was completed for incident when resident slide out of the EZ stand sometime in March of 2023. The resident's assesment dated February 7, 2023, completed by ALDIR-D when she was employed as a registered nusre by the facilty, indicated the resident required an EZ stand for transfers but did not specifiy the number of staff members required. The resident's assessment dated February 26,	02310		

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02310	Continued From page 3 2023, completed by ALDIR-D when she was employed as a registered nurse by the facility, indicated the resident required an EZ stand for transfers but again did not specifiy the number of staff members required. The same document indicated the interventions for falls prevention included a pendant to call for help, wheelchair for mobility, and mechanical lift (EZ stand) for transferring. An observation on October 17, 2023, at 11:05 a.m., licensed practical nurse (LPN)-B and unlicensed staff (ULP)-H transferred R2 from bed to wheelchair using the EZ Stand and a medium-size sling. The medium sling was squeezing skin together near R2's upper chest and upper abdomen requiring the staff to pull on the sling belt, with more than minimal handling, in order to clasp the belt. During an interview on October 17, 2023, at 12:57 p.m., R2 stated he requires a wheelchair at all times and an EZ Stand for transfers. R2 stated when he was transported to the facility from the hospital, he was in a wheelchair either from the hospital or the transport company. R2 stated he did not have his own wheelchair and upon arrival to the facility a wheelchair was not available for him. R2 remained in the larger wheelchair that he was transported in, but the wheelchair was too large to fit through his apartment door. R2 stated it took a while for the facility to get a wheelchair for him. R2 stated the EZ stand was owned by the facility and is not his own personal equipment. R2 stated one time during a transfer the strap slid off the EZ Stand causing R2 to drop to the floor. R2 stated a latch was missing on the EZ Stand which is needed to keep the strap from sliding off the lift arm. R2 further stated the sling used to hook him up to the EZ Stand is one size too small	02310		

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02310	Continued From page 4 and pinches his skin during transfers. During an interview on October 16, 2023, at 12:45 p.m., assisted living director in residency (ALDIR)-D stated when R2 fell out of the EZ Stand a report was not completed as ALDIR-D understand the ULP who witnessed the fall would complete a report. During an interview on October 17, 2023, at 12:02 p.m., registered nurse (RN)-A stated the sling size for weight does not take into account the girth of the resident and would require the next size up. During an interview on October 17, 2023, at 3:00 p.m., assisted living director in residence (ALDIR)-D, who is also a registered nurse, indicated a pre-admission assessment was conducted over the phone. ALDIR-D stated the facility did not have a wheelchair for R2 when he arrived and had to order one. ALDIR-D stated she was the first person to transfer and assess R2 on admission, but indicated she did not document her assessment of the transfer. ALDIR-D stated she called medical equipment to order a new wheelchair that would accommodate R2's size and that would fit through the apartment doorway. ALDIR-D stated the durable medical equipment provider did not come to the facility physically to assess R2 but requested measurements via phone. ALDIR-D stated it took four to six weeks for the wheelchair to arrive. ALDIR-D stated the EZ Stand is owned by the facility. ALDIR-D stated there were no maintenance logs available or working orders to show equipment owned by the facility was properly maintained. ALDIR-D stated she was not aware the missing safety clamp located on the arm of the EZ Stand which is required to	02310		

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02310	Continued From page 5 prevent the sling from sliding off during a transferring. ALDIR-D stated the size harness/sling that is used with the EZ Stand to transfer the resident was the correct size as the sling according to weight. ALDIR-D stated she used the weight of R2 provided by the hospital rather than obtain a weight on facility admission and used the medium size sling provided by the facility based on recommended weight limits rather than take into consideration the resident's size. The EZ Way, Inc. manual, dated December 27, 2019, indicated the stand requires a minimum of servicing to keep the equipment in good working order. The same document indicated there were basic checks to be completed periodically by a maintenance staff to ensure on-going safety throughout the life of the device. One of the safety checks included ensuring safety needs are the lift are installed correctly, not missing, or torn. The EZ Way Smart Stand Operator's Instructions manual, revised June 14, 2023, indicated EZ Way harnesses are designed to be applied or removed with a minimum amount of handling of the patient. As patients do vary in size, shape, and weight, these conditions must be taken into consideration when deciding the size of the EZ Way harness as there are a variety of sizes available. The licensee Assessment Regarding Safe Use of Assistive Devices Policy, not dated, indicated the facility will promote the safe use of assistive devices through individualized client assessments and follow-up. The licensee 6.01 Assessments, Reviews &	02310		

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02310	Continued From page 6 Monitoring policy dated August 1, 2021, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R2) was free from maltreatment. R2 was neglected. Findings include: On December 5, 2023, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		