Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349684523M
Compliance #: HL349687667C

Date Concluded: March 16, 2023

Name, Address, and County of Licensee Investigated:
Willow House
25611 110th St.
Zimmerman, MN 55938
Sherburne County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, 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), facility staff, neglected a resident when they failed to follow the residents plan of care to use a transfer belt. As a result, the resident fell and sustained a shoulder fracture and sprained ankle.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It could not be determined if the AP attempted to follow the resident's care plan and use a transfer belt the

day of the incident. The AP and resident could not recall if the transfer belt was offered and refused by the resident the day of the incident.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, employee records, incident reports, facility investigation documentation, and after visit summaries from the emergency department and orthopedics. In addition, observations were completed of staff assisting the resident to transfer and ambulate using a transfer belt.

The resident resided in an assisted living facility with diagnoses including stroke, and hemiplegia (paralysis) affecting the left side. The resident's assessment indicated she was alert and oriented and was at a risk for falls related to problems with muscular coordination following a stroke. The assessment and resident's care plan identified she had left sided paralysis and required one staff physical assistance using a transfer belt, and quad cane for transfers.

An incident report indicated six days after the resident was admitted to the facility, the resident was transferring from the bed to the wheelchair with the AP's assistance, when the resident stumbled and fell onto her left shoulder. The resident complained of pain, and 911 was called. The facility incident report indicated the AP did not use a transfer belt as indicated in the resident's care plan.

The resident's emergency department after visit summary indicated she was seen for a injury related to a fall and sustained a proximal humerus fracture and sprained ankle.

A facility progress note indicated the AP reported the resident had declined using the transfer belt previously in the shift. However, the resident record lacked any documentation of the resident's refusal to use a gait belt.

A review of the facility investigation indicated when interviewed, the resident stated she was not wearing a transfer belt at the time of the fall, but the AP was holding onto her. The resident stated she never used a transfer belt prior to admission to the facility. The resident stated she felt capable to transfer if someone was holding onto her and had refused to wear the transfer belt with facility staff since admission.

During an interview the AP stated the resident did not want to use the transfer belt. The AP stated she felt more comfortable using a transfer belt and believed she would have encouraged the resident to use one. The AP could not recall if the resident was offered and refused the transfer belt at the time of the fall.

When interviewed the resident stated she missed a step during the transfer and fell towards her paralyzed side onto her shoulder. The resident stated when she was first admitted to the facility the transfer belt was not consistently used, but indicated staff always use a transfer belt since the fall.

In conclusion, it was inconclusive whether neglect occurred.

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:
(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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility assessed the resident’s injuries and called 911. The facility investigated the incident and provided re-education on transfers and following the resident’s care plan. The facility added use of transfer belt to the resident’s services to provide documentation and monitoring of compliance and refusal.

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
	34968	A. BUILDING: _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW HOUSE LLC	25611 110TH STREET NW ZIMMERMAN, MN 55398

(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 28, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL349684523M/#HL349687667C. No correction orders are issued.	0 000		