Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357955781M
Compliance #: HL357958082C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
Havenwood of Burnsville
14401 Grand Avenue South
Burnsville, MN 55306
Dakota County

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

Evaluator's Name: Willette Shafer, RN
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 facility neglected the resident when the facility failed to provide staff assistance for transfers and the resident fell acquiring injuries to the face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed the resident as an increased risk for falls and implemented several interventions to prevent the resident from falling before the incident. The resident was able to transfer independently using a walker. During the incident, a staff member assisted the resident to transfer between wheelchairs with a walker. The resident's legs gave out and she fell during the transfer. After the incident, nursing and physical therapy assessed the resident and met with the family to discuss additional interventions including two staff assistance with a mechanical lift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident and their family member. The investigation included review of the resident's record, personnel files including training records, facility incident reports, staff schedules, and related facility policy and procedures Also, the investigator toured the facility and observed staff members assisting with resident transfers.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis, repeated falls, osteoporosis, and anxiety. The resident's service plan indicated the resident received services including medication administration, stand by assist during bathing and toileting. The resident's service plan indicated the resident was independent with transfers and mobility, utilizing a wheelchair and walked independently in her room with a walker; however, the resident also required stand by assistance for transfers to toilet. The service plan also identified fall risk interventions, which included educating the resident to use her call pendant, wear proper footwear, encourage use of her assistive device, keep environment safe from fall hazards, physical therapy services and provided staff training on proper transfers/lifting.

The resident's record included her fall history. The resident experienced several falls in the months prior to the incident. The resident had a history of self-transferring and calling staff for assistance after she had fallen. The facility provided education of importance to request help prior to transfers, the resident worked with physical therapy and installed a grab bar. The facility increased toileting assistance from four times per day to six times per day.

Approximately one week prior to the incident, the facility had a care meeting with the resident, her family member, the facility nurse, and facility leadership. Discussion included concerns regarding difficulties transferring and requiring two unlicensed personnel (ULP), and physical therapy's report of the resident's declination of therapy appointments. The summary indicated the facility would assist the resident in finding a new facility that could support two-person transfer assistance.

The facility incident report indicated an ULP was present with the resident in her room. The resident tried to transfer from a manual wheelchair to a motorized wheelchair with her walker. The resident was unable to support her weight and fell forward over her walker to the floor, hitting her nose and mouth. The resident's nose had a small amount of bleeding. Facility staff sent the resident to the hospital for evaluation and updated family. The resident's progress notes indicated the resident returned to the facility the same day.

The facility's internal investigation indicated ULP 1 was interviewed after the incident. ULP 1 stated she was assisting the resident and had the gait belt in place when the resident "got up" and fell forward.

Per ULP 1's training record, the facility provided training to ULP 1 on safe transfer techniques and resident care plans.

The facility completed a change of condition assessment on the resident after the incident. The assessment indicated the resident had decreased mobility, balance and had an unsteady gait. The resident required extensive assistance with two ULP and a mechanical lift. The resident's service plan was updated to reflect the change in transfer assistance.

Per communication notes, following the incident, the resident declined physical therapy appointments for approximately two weeks. Physical therapy notes completed after the change in condition assessment indicated the resident's fatigue level fluctuates and the resident can range from stand by assist to maximum assist for transfer. Physical therapy indicated the resident was unsafe with one person transfer assistance due to inconsistencies of strength and knee buckling.

Approximately one month later, the resident discharged to a new facility.

During an interview, ULP 1 said she assisted the resident during the incident. She applied a gait belt and the resident stood up with the walker in front of her. She positioned wheelchairs next to each other. The resident's legs "legs gave out" and she fell forward. The facility called for emergency services because the resident was bleeding, and she was sent to the hospital. ULP 2 was present after the fall, and they did not move the resident because they were unsure of her injuries.

During an interview, ULP 2 responded to a call for assistance. When she arrived, the resident was on the floor and had blood on her nose. They left the resident still and called for emergency medical services because they were unsure of her injuries. She said the resident had a transfer belt on when she arrived. She said the resident had many falls since admission. When the resident returned from the hospital, she was a mechanical lift, but the resident continued to transfer herself independently. She declined a mechanical lift and complained staff failed to use their full strength and could transfer her with their strength if they wanted.

During an interview, a member of management said the resident was independent with transfers before the incident. The resident wanted to maintain her independence as long as possible despite several falls since her admission. The facility implemented several interventions to decrease the risk of falls. After the incident, the nurse and physical therapy assessed the resident, and the assessments indicated a mechanical lift was needed to safely transfer the resident. At times the resident's legs would give out and the weight was too much for staff to bear. The resident and family declined to use of a mechanical lift. They wanted the resident to maintain her independence and felt a mechanical lift was unnecessary.

During an interview, the family member said the resident reported she called for assistance with transferring. The resident used a walker and staff assist with transfer belt to transfer. The

ULP who assisted with the transfer never applied a transfer belt and was untrained. She said when the resident pivot turned the ULP put her hand on her back and pushed her. She denied the staff member pushed the resident intentionally but said she should not have put her hand on the resident's back. Sometimes people with multiple sclerosis, their legs give out. She said the facility waited two hours after the incident to call her. After the resident returned, the facility wanted the resident to use a mechanical lift for transfers, but the resident and family wanted to maintain the resident's independence.

During an interview, the resident said she asked ULP 1 to "boost" her up. She said ULP 1 said she could not boost her up. During the transfer ULP 1 placed her hand on the resident's back to steady her. The resident fell forward over her walker. Facility staff called for emergency medical assistance. After she fell, the resident wanted ULP 1 and ULP 2 to get her up, but staff declined to move her. She said paramedics arrived and assisted her to the gurney. She said staff watched the paramedics but did not help them. She said staff should have helped get her off the floor when paramedics were present. After she returned from the hospital, the facility wanted her to use a mechanical lift. The resident felt a mechanical lift was unnecessary and she wanted to maintain her independence.

In conclusion, the Minnesota Department of Health determined 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 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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility implemented fall interventions and the resident had physical therapy services prior to the fall. The facility called for emergency services after the incident. The facility completed an internal investigation, assessed the resident, and increased her level of transfer assistance to

two staff with a mechanical lift. The resident continued with physical therapy services after the fall. The facility held care meetings with the resident and family.

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
	35795	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF BURNSVILLE	14401 GRAND AVENUE BURNSVILLE, MN 55306

(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 21, 2024, the Minnesota Department of Health initiated an investigation of complaint HL357958082C/HL357955781M. No correction orders are issued.	0 000		