Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5530048M **Date Concluded: December 18, 2019**

Name, Address, and County of Licensee Investigated:
Samaritan Bethany Home on Eighth
24 8th Street North West
Rochester, MN 55901
Olmsted County

Facility Type: Nursing Home

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
An investigator from 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.

Allegation(s):
It is alleged: The alleged perpetrators (AP #1 and AP #2) abused a resident when abrasions were found on the resident's forehead, and bruising on the resident's head and leg.

Investigative Findings and Conclusion:
It was inconclusive whether abuse occurred. The resident gave inconsistent reports as to the nature of the injuries and no staff working at the time of the injuries witnessed or confirmed who, if anyone, harmed the resident.

Neglect was substantiated. The facility was responsible for the neglect. The resident wandered into other resident rooms and the facility had determined the resident required one staff assigned to observe the resident at all time but failed to ensure sufficient staff available for the direct supervision. The resident had injuries of unknown origin after a night with no direct supervision by staff.

The investigation included interviews with facility staff, including administrative staff, nursing staff, unlicensed staff, and family members. In addition, the investigator contacted law enforcement and reviewed law enforcement documentation. The investigator reviewed the resident's medical record, facility investigation, incident reports, policies, and procedures.

The resident admitted to the facility due to diagnoses that included a recent cervical fracture after a fall and dementia. The resident wore a cervical collar for neck support. The resident had moderate cognitive impairment with confusion and poor memory. The resident required supervision of one staff with a gait belt and walker for mobility and had a history of wandering into other residents' rooms as well as falls.

The resident's care plan indicated she required assistance with dressing, grooming, bathing, incontinence cares, transfers, and mobility. The resident required a walker, gait belt, and one staff to ambulate. The resident used a wheelchair for longer distances. The resident wandered into other resident rooms and the facility assigned one staff to observe the resident at all times but often did not have enough staff.

One morning a family member noticed the resident had scratches and bruising on her forehead that were not there the day before. The family member viewed an additional large bruise on the resident's leg. Nursing staff did not know how the injuries occurred. The family member contacted police, who came to the facility and interviewed the resident, as well as the two staff working the previous night, AP #1 and AP #2.

The police report indicated the resident was unable to provide a consistent statement and after additional investigation, found no evidence to indicate an assault had occurred.

During interviews, several unlicensed staff said that the facility did not always have staff for the direct supervision of the resident. The staff said that the resident often wandered around the unit into other residents' rooms.

During an interview, a nurse said that when there were not enough staff for the direct supervision of the resident, staff would check on the resident every 15 to 30 minutes. The nurse said that on the night prior to the discovery of the resident's injuries, there was not a staff assigned for direct supervision.

During an interview, AP #1 said on the night of the incident there was no staff for the resident's direct supervision, the resident wandered into others' rooms, and was agitated. AP #1 said that she and AP #2 brought the resident into her room to change her incontinence brief and it was at that time they noticed a bruise on the resident's forehead. AP #1 said that she did not know how the bruised happened, but wondered if the resident bumped her head on something while walking as she always walked with her head down. AP #1 said that she did not hit or kick the resident.

During an interview, AP #2 said AP #1 asked her to help put the resident to bed because the resident had been wandering around the unit. AP #2 said there was no assigned staff for direct supervision of the resident. AP #2 said that she saw scratches on the resident's head. AP #2 said the resident was confused, but did not struggle to go to bed. AP #2 said neither AP #1 nor AP #2 harmed the resident.

During an interview, a family member said that the resident told her that a staff had beat her up. The family member said that the resident gave a name, but there were no staff at the facility by that name. The family member said that she was convinced that the resident was agitated, roaming around during the night, and someone harmed her.

In conclusion, it was inconclusive whether abuse occurred and neglect was substantiated.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

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: No, the resident was unable to participate in an interview
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes, AP #1 and AP #2.

Action taken by facility:
The facility provided retraining to staff on abuse and neglect and began documentation accountability for direct supervision staff.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00427	A. BUILDING: _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5530048M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 are issued for #H5530048M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from	21850		

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21850	Continued From page 2 non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review the facility neglected to ensure staff were assigned to provide direct supervision for one of one residents (R1) reviewed for maltreatment. R1 as assessed to need direct supervision by staff, staff were not able to perform direct supervision, and R1 was found to have scratches on her head and bruises on her leg of unknown origin. Findings include: R1's record was reviewed. R1 admitted to the facility on March 25, 2019 for rehabilitation after a fall resulting in a broken cervical bone. R1's diagnoses included dementia, fracture of second cervical vertebrae, and traumatic subdural hemorrhage. R1's bedside Kardex dated March 25, 2019 indicated R1 required help of one caregiver with a gait belt and four wheeled walker to ambulate. R1's brief interview of mental status (BIMS) dated April 1, 2019, indicated R1 had moderate cognitive impairment. R1's care plan revised May 7, 2019, directed staff to remove R1 from potentially dangerous situations. R1's progress note dated April 16, 2019 at 12:52 a.m., indicated R1 wandered into the hallway and attempted to enter a peer's room. R1's progress note dated April 26, 2019 at 9:00	21850	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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	

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21850	Continued From page 3 p.m., indicated staff found R1 sitting on the floor next to a recliner and before the nurse came back with the mechanical lift, R1 was off the floor and sitting in the recliner. R1's progress note dated May 6, 2019 at 1:18 a.m., indicated a new bruise was found on R1's right hip. R1's progress note dated May 6, 2019 at 8:54 p.m., indicated R1 had been wandering all over the unit and was found in a peer's room sitting on the bed while the peer slept. The note further indicated R1 repeatedly walked into other rooms and almost out the door of the unit. R1's progress note dated May 7, 2019 at 6:37 a.m., indicated R1 entered a peer's room, removed her own incontinence brief, and urinated on the peer's chair. R1's progress note dated May 7, 2019 at 11:02 a.m., indicated one to one (1:1) staffing (one staff present with R1 at all times) started due to R1's increase in wandering. R1's progress note dated May 10, 2019 at 7:38 a.m., indicated R1 attempted to wander the unit and into peers' rooms. R1's progress note dated May 11, 2019 at 11:30 a.m., indicated R1's family discovered abrasions on R1's forehead and a bruise on R1's left leg. The note indicated the bruise on R1's leg measured 5 inches x 2 inches, an abrasion on R1's head measured 0.5 inches x 0.5 inches, an abrasion in the middle of R1's forehead measured 4 centimeters (cm) x 1 cm, and one laceration on the right side of R1's head measured 1 cm long, and another laceration on	21850	SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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21850	Continued From page 4 R1's head measured 2.5 cm long. During an interview on December 3, 2019 at 11:00 a.m., registered nurse (RN)-B stated R1 was supposed to be on 1:1 staffing during all three shifts, but if there were not enough staff it was okay to observe R1 every 15 or 30 minutes. During an interview on December 3, 2019 at 12:00 pm, nursing assistant (NA)-C stated she worked on the night of R1's incident and did not know how R1 got injured. NA-C stated the facility did not provide a 1:1 staff for R1 on the night of the incident, as they could not find anyone to work. NA-C stated it was her, another aide (NA-H) and a nurse (RN-E) working. During an interview on December 3, 2019 at 2:25 p.m., family member (FM)-D stated the facility placed R1 on a 1:1 four days before the incident, due to R1's risk of falling. FM-D stated R1 did not have bruising or cuts on her face when FM-D saw R1 two days prior to the incident. FM-D stated R1 told her someone beat her up on the night of the incident and spoke about a black man and there being blood on hands. FM-D stated R1 gave conflicting information to the police and the facility told FM-D that R1's injuries may have happened during a fall. During an interview on December 6, 2019 at 8:56 a.m., RN-E stated there was no staff assigned for R1's 1:1 on the night of the incident. RN-E stated she checked on R1 once during the night and did not recall seeing any scratches. During an interview on December 18, 2019 at 11:30 a.m., NA-H stated R1 had no assigned 1:1 staff on the night of the incident. NA-H stated during the night NA-H discovered R1 in the dining	21850		

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21850	Continued From page 5 room, and also trying to get into another resident's room. NA-H stated she called her coworker (NA-C) to assist her with changing R1 and that is when she saw R1 had a bruise on her forehead. NA-H stated she did not know how R1 got the bruise, but she (NA-H) did not hit R1. The Abuse Prevention Plan of Vulnerable Adults dated February 2019 defined neglect as 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 reasonable and necessary to obtain or maintain a vulnerable adult's physical or mental health or safety. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days	21850		