Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55681404M
Compliance #: H55682069C

Date Concluded: January 26, 2023

Name, Address, and County of Licensee Investigated:
Good Samaritan Mary Jane Brown
110 South Walnut Avenue
Luverne, Minnesota 56156
Rock County

Facility Type: Nursing Home

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Substantiated, individual responsibility

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), a staff member, emotionally abused a resident when the AP yelled at the resident on multiple occasions and would not provide cares to the resident when the resident requested assistance. As a result, the resident was emotionally distraught and withdrew from activities to prevent being yelled at by the AP.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP denied not providing services or raising her voice to the resident, however, information in the AP's employment record and accounts from staff members indicated there were multiple instances when the AP yelled at the resident and instances when the AP would not provide bathroom cares when the resident requested which caused the resident to be emotionally distressed and not engage in activities.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, staff records, and policies and procedures.

The resident resided in a nursing home and had diagnoses including Parkinson's disease. The resident's care plan included assistance with mobility, transferring, toileting, and personal hygiene. The resident's assessment indicated the resident did not have behavior problems, needed a toileting program, and needed extensive assistance with toileting and transfers.

Review of the AP's employment record indicated she was given verbal reminders to listen and complete instructions given by the charge nurse, to complete incontinent resident cares immediately when the charge nurse brings the issue to her attention, to be aware of the contents of and to follow resident's care plan, to manage frustration levels, and to speak nicely over the walkie communication system. The AP received a text message reminder to complete resident peri cares every A.M. and P.M. with soap and water and washcloths, to take residents to the toilet, not to tell residents to go to the bathroom in their padding, and to change a resident's soiled brief right away when the resident communicated the need.

A manager evaluation note in the AP's record indicated the AP was not meeting expected job requirements and the AP needed to improve the following: toileting residents when residents express the need to use the toilet, assisting residents to the bathroom and not telling residents to use their padding as an alternative, completing bedtime cares using proper oral care and bathing procedures, completing resident baths as scheduled and only giving bed baths when a resident is unable to be taken to the tub and the nurse gives permission, removing soiled linen and clothing and garbage every evening and leaving residents rooms in an orderly appearance, treating residents with respect in response to their needs, keeping a friendly tone of voice and not making resident feel like their needs are a burden, and treating residents with dignity and respect.

During an interview an unlicensed personnel member stated she was asked to provide cares to the resident after the AP told the unlicensed personnel member she changed the resident's soiled brief. The unlicensed personnel member checked on the resident and found the resident's brief soaked and dripping with urine. The unlicensed personnel member then changed the resident's brief and cleaned up the urine while the resident cried and stated the AP treated her "really badly", treated her "like I'm a nobody", and "doesn't do what I need".

During an interview a second unlicensed personnel member stated she heard the AP yelling at the resident. The staff member stated when she worked, she tried to be assigned as the resident's caregiver, so the AP didn't take care of the resident. The staff member stated the AP "singled out the resident" and was unkind to the resident. The staff member stated the resident told her the AP would yell at her if she did not walk quickly enough to the dining room. The resident stopped walking to the dining area for meals because the AP made her feel like a burden and the resident wanted to avoid being yelled at. The staff member stated she heard

the AP yell at the resident when she soiled her brief and scolded the resident for not putting on the call light to use the bathroom. The resident also reported the AP would yell at her if she would put her call light on too many times and the AP would turn off the resident's call light without providing care.

During an interview, a nurse stated the resident did not like to complain and would only report a concern to staff members she trusted. The nurse stated if the AP "was in a bad mood she could be very short with people". The nurse stated the AP became "very irritated" if she thought a resident used their call light too often or asked for too much assistance. The nurse stated the resident reported to her on multiple occasions the AP was rough with her and did not help her. The nurse stated the resident appeared "very depressed" about how the AP treated her.

During an interview, a family member of the resident stated on multiple occasions the resident reported the AP would tell her she didn't have time for her, and that the resident was too needy.

During an interview, the AP stated she enjoyed working at the facility and caring for residents. The AP denied yelling at residents, not providing cares, or telling residents to urinate in their briefs and stated she had a good relationship with the resident.

In conclusion, the Minnesota Department of Health determined abuse 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.

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;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, due to current health status
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Alleged perpetrator is no longer employed by 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 651-201-4200 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
Rock County Attorney
Luverne City Attorney
Luverne Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00575	A. BUILDING: _____ B. WING _____	C 12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BF	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

(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 #H55681404M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000		

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2 000	Continued From page 1 #H55681404M, 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 "reviewed" 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		
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 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.	21850		

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: The facility failed to ensure 1 of 1 residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	