Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL245546927M
Compliance #: HL245541577C

Date Concluded: February 5, 2025

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Heritage Grove
2208 River Road NW
East Grand Forks, MN 56721
Polk County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 alleged perpetrator (AP), a facility registered nurse (RN), neglected the resident when he failed to seek immediate treatment for an acute change in condition and failed to provide additional monitoring or supervision after he was notified of the resident's increased complaints of pain after a fall. The resident was later diagnosed with a fractured rib.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It could not be determined if neglect occurred. Although the RN did not initially assess the resident, the resident was administered pain medication and declined to be seen in the emergency room. Staff reported the resident's complaints of pain to another nurse who assessed the resident and sent the resident to the hospital for an evaluation where she was diagnosed with a rib fracture.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record,

hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the area where the resident fell.

The resident resided in an assisted living facility. The resident's diagnoses included heart disease and glaucoma. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident did not have a history of falls and was independent with walking and transfers.

A fall incident report was created by unlicensed personnel (ULP) on Saturday after the resident fell. Injuries including a skin tear on her right elbow and a small scrape to her back were noted. The fall incident report was reviewed and completed by the AP/RN on Sunday, the day after the resident fell. A loss of balance was listed as the root cause of the fall. The AP/RN signed his name indicating he had reviewed the incident report. The AP/RN did not enter any progress notes related to the incident and did not document if he took any steps to assess the resident.

The next morning, the resident requested Tylenol for back and left side pain. Documentation indicated that the resident showed staff where the pain was coming from in the lower ribs area. The resident stated that it was the same area from when she fell backwards the last time. When staff followed up to see if the Tylenol helped with her pain, the resident reported that it didn't work and was noted to be holding her left side near her ribs. Staff asked if she thought she should get checked out and the resident stated, "they won't do anything." Staff told the resident it would be good to know if you bruised them or broke them. The resident agreed with staff but still was unsure if she wanted to go to doctor. Before going to bed on Sunday, the resident received another dose of PRN Tylenol. On Monday morning, another facility nurse followed up with the resident after being updated of ongoing pain and sent the resident to the emergency room.

Hospital records indicated the resident was diagnosed with a rib fracture. She was treated in the emergency room and discharged back to the facility.

During an interview, a ULP stated she had worked the weekend when the resident fell and when the pain got worse on Sunday, she told the AP/RN about it and he told her he'd check on her but when he hadn't, she asked again if he was going to, and he replied again that he would. The ULP stated she spoke with the AP/RN in the nurse's station and was telling him how much pain she was in but she didn't feel like he was listening to her. The ULP stated she sent a message to another facility RN that evening asking her to check on the resident when she came in Monday morning.

During an interview, the nurse manager stated the AP/RN was scheduled to work that Sunday and he would have been responsible for following up with any nursing related issues. The nurse manager stated the AP/RN would have been aware of the resident's increased pain from verbal reports, communication on Webex (an electronic messaging system) and alerts that the

resident was using PRN/as needed Tylenol in the electronic medical record. The nurse manager would have been expected the AP/RN to follow up with the resident regardless of pain due to needing to complete a fall assessment and assess the skin tear.

During an interview, facility management stated she interviewed the AP/RN after the incident occurred and he admitted to not going in to check on the resident when he was in the building. Facility management stated she asked him why he failed to do so, and the AP/RN told her he had been busy and one of the ULPs told him “what’s the point now” so he decided not to. Facility management stated the AP/RN would have been expected to assess the resident in person while completing the fall incident report and respond to concerns raised by ULP.

During an interview, the AP/RN stated he had intended to check on the resident when he was at work that Sunday but when he was going to, a ULP asked him “why, she’s fine” so he decided to not check in on the resident. The AP/RN stated he was not told of any concerns with the resident’s pain and that the only pain she had was her usual pain, nothing new. The AP/RN stated it would not have been required for him to go check on the resident but stated it would have been best practice to assess her in person.

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

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 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: Yes

Action taken by facility:
The facility reported the incident to MAARC and suspended the AP/RN pending investigation. The AP/RN was later terminated for violating the facility’s policy regarding assessing residents after falls.

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
	24554	A. BUILDING: _____ B. WING _____	C 12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-HERITAGE GROVE	2122 RIVER ROAD NW EAST GRAND FORKS, MN 56721

(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 December 27, 2024, the Minnesota Department of Health conducted a complaint investigation HL245541577C/HL245546927M at the above provider. No correction orders are issued.	0 000		