Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294982940M
Compliance #: HL294982670C

Date Concluded: September 16, 2024

Name, Address, and County of Licensee Investigated:
Good Samaritan – International Falls
2101 Keenan Drive
International Falls, MN 56649-2163
Koochiching County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when the facility did not respond to the changes in the resident's condition. The resident was emergently sent to the hospital and died the same day from sepsis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assisted the resident during an incontinence episode and assisted with hygiene care. The facility called for emergency services when the resident continued to have incontinence, became pale and was unable to follow bathing directions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident record, death record, and hospital records. A review of facility incident reports, personnel files, staff

schedules, and related facility policy and procedures. Also, the investigator interviewed and observed residents in the facility setting at the time of the facility visit.

The resident resided in an assisted living facility with a diagnosis of Alzheimer's disease and high blood pressure. The resident's service plan included facility assistance with medication administration and meals. The resident's assessment indicated she was independent with bathing, dressing, grooming and was incontinent of bladder. The resident had memory loss and required reminders for activities.

The nursing progress notes indicated one night the resident needed increased assistance. The resident had bowel incontinence, which was unusual for her, so the unlicensed caregiver called the on-call nurse and updated her. The nurse instructed the caregiver to assist with the resident's shower. However, the caregiver called the nurse again as the resident had a second incontinence episode and was not able to follow directions during the shower which was unusual for her. The nurse instructed the caregiver to call immediately for an ambulance.

During an interview, the nurse stated that the resident had a typical day and participated in all her usual activities without complaints. She stated that evening, the resident repeatedly asked staff what time it was, which was her norm, but she was slightly more confused and anxious. The nurse stated this was not completely out of her normal, as she did have anxiety, and she did get confused at times. Staff were able to calm her, and the resident went to bed with no issues. She stated she instructed staff to watch for additional changes.

During interview, an evening shift caregiver stated the resident was slightly more confused but could be redirected and went to bed without further issues.

During interview, the caregiver, who worked the night shift, stated the report from the prior shift was that the resident was not feeling well and to keep an eye on her. The caregiver entered her room early in the shift and the room temperature was set at 60 degrees and cold, so the temperature was adjusted. The caregiver asked what was wrong and the resident replied that she did not feel well. When the caregiver returned a bit later, the resident had soiled her bedding, so the caregiver assisted the resident to the shower and changed her bed linens. The caregiver stated on this occasion the able to walk on her own to the bathroom. The caregiver updated the on-call nurse as the incontinence was a change in the resident's baseline, although vital signs were normal, and the nurse said to monitor the resident. Later, around 4:45 a.m., the caregiver returned and found she had soiled the bed again but this time the resident was paler, required increased assistance getting in the shower, and unable to follow directions in the shower. The caregiver called the nurse again and they agreed that emergency services needed to be called. The caregiver stated the resident needed assistance onto the bed from the shower chair by lifting her around her abdomen and the resident did not complain of abdominal pain during these cares.

During an interview, the director stated that she followed up with staff to see what they did for the resident throughout the night and stated the caregiver checked on her frequently.

During interview, a family member stated she was with the resident the day prior, and noted the resident had a good day without any complaints. When the family member was informed of the bowel perforation, there was concern that the resident may have been injured during cares that night at the facility.

The hospital records indicated upon arrival to the emergency room, the resident was drowsy and could not verbalize her symptoms. The resident's abdomen was mildly distended and tender. Hospital testing indicated she had a bowel perforation, a liver abscess, extensive abnormal laboratory values and hemolytic anemia.

The resident passed away that morning in the hospital. The resident's death record listed the cause of death was septic shock and intestinal rupture and the manner of death was natural.

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: No, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	29498	A. BUILDING: _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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 August 6, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL294982670C/#HL294982940M. No correction orders were issued.	0 000		