Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52211081M
Compliance #: H52217706C

Date Concluded: August 8, 2024

Name, Address, and County of Licensee Investigated:

Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, MN 55117
Ramsey County

Facility Type: Nursing Home

Evaluator's Name: Erin Johnson-Crosby, 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.

Initial Investigation Allegation(s):
Facility staff abused the resident when they held the resident down to complete urinary catheterization (drain the bladder and collect urine) procedure after the resident told them to stop.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information and a lack of documentation provided, it was unable to be determined if abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, federal investigation documentation and interviews, staff schedules, and related facility policies and procedures.

The resident resided in skilled nursing facility. The resident's diagnoses included left tibia (shin bone) fracture and urinary retention. The resident's care plan indicated the resident required assistance with toileting, dressing, bathing, and transfers. The resident's assessment indicated the resident had no cognitive deficits and could verbally communicate her needs.

Complaint documents indicated that facility staff held the resident down, spread the resident's legs apart and inserted a urinary straight catheter (a soft, thin flexible tube inserted into the urethra) after the resident declined the procedure. Following the procedure, law enforcement was contacted, and a police report was filed.

Review of the resident's medical record included a physician's order for nursing staff to complete a postvoid residual (PVR) scan (a scan of the bladder used to determine the amount urine remaining in the bladder after voiding) on every shift due to urinary retention. If the PVR was greater than 350 cubic centimeters (cc) staff were to use a straight catheter to empty the resident's bladder.

The resident's medical record from the date of the alleged incident, indicated staff obtained a PVR scan reading of 550 cc. There was no documentation to indicate that the straight catheter procedure was completed or that the resident refused the procedure.

During investigative interviews, staff who worked the day of the incident recalled that the resident's PVR was above 350 cc, so they catheterized the resident. Three staff were required to perform the procedure; two staff held the resident's legs, and another staff member completed the procedure. One staff member recalled that the resident said they were "ripping her apart" but at the time, no one was touching the resident. Another staff asked the resident if they should stop and come back later, and the resident told them to "just get it done". Staff stated that the resident did not tell them to stop at any time during the procedure.

During an interview, the resident stated at the time of the incident, two staff pulled her legs apart while another staff attempted to place the catheter. The resident stated that one staff member told the other two to pull her legs apart and staff pulled her legs further and further apart causing severe pain. The resident told staff to stop multiple times because they were hurting her, but staff continued with the procedure. The resident reported that she had an increase in anxiety following the incident and discharged from the facility due to concerns with the care provided by staff.

During an interview, the resident's family member stated they were with the resident at the time of the procedure. The family member stated that staff grabbed the resident's legs and kept pulling them further and further apart and the resident asked staff to stop because they were hurting her. The family member stated that they left the room upset after staff continued with the procedure and did not listen to the resident's request for them to stop. The family member stated that a police report was filed but when they attempted to obtain a copy of the report, there was no report on file.

Administrative staff reported to federal surveyors that they were not aware of the incident and were not informed on the details of the incident. Administrative staff stated that residents have the right to refuse care and staff should have immediately stopped the procedure when the resident told them to stop. Administrative staff stated they expected staff to honor resident rights and their right to refusals of care.

Law enforcement indicated there was no record of a police report filed in relation to this incident.

In conclusion, the Minnesota Department of Health determined abuse 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.

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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
Re-education was completed.

Action taken by the Minnesota Department of Health:

For maltreatment-only at federally certified providers that are not substantiated or are inconclusive:

MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00900	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 #H52211081M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		