Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52339306M
Compliance #: H52336514C

Date Concluded: January 29, 2024

Name, Address, and County of Licensee Investigated:
Saint Anne Extended Healthcare
1347 W 6th St 209
Winona, MN 55987
Winona county

Facility Type: Nursing Home

Evaluator's Name: Holly German, 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(s):
The alleged perpetrator (AP) neglected the resident when the AP failed to timely activate emergency medical services and gave the resident juice orally when she was unresponsive.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP assessed the resident, notified her supervisor and the residents family. While there was delay in activating emergency medical services, there was no adverse outcome for the resident as a result.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and paramedic staff. The investigator contacted a family member. The investigation included review of the resident's internal and external medical records, personnel records, and the internal investigation.

The resident resided in a skilled nursing facility. The resident's diagnoses included senile degeneration of brain, cardiomyopathy, and chronic obstructive pulmonary disease. The resident's service plan included assistance with transfers, bed mobility, eating, drinking and medication administration. The resident's assessment indicated the resident had diminished cognitive ability and use of a wheelchair.

An unlicensed staff member notified the AP the resident was unresponsive. The AP assessed the resident, who responded to verbal command. The resident had a low blood sugar. The AP provided orange juice and glucagon (an injection of glucose) to the resident. The AP notified her supervisor and the resident's family. The resident's family requested the resident go to the emergency room for evaluation. The AP called emergency medical services (EMS).

Facility nurses progress notes, authored by the AP, indicated the resident was unresponsive with a blood sugar of 37, and called EMS one hour and twenty-five minutes later.

An ambulance dispatch record indicated the ambulance company dispatched approximately one hour and twenty-five minutes after the nurse noted the resident to be unresponsive.

An emergency department provider note indicated no known medical cause for the low blood sugar episode.

During an interview, an EMS staff stated their dispatch report indicated the facility staff noted the resident was unresponsive three hours before they received dispatch to the facility. Upon arrival to the facility, the AP told EMS she gave the resident orange juice by mouth by physically holding the residents mouth open. EMS staff stated the AP said she contacted the family an hour after noting the resident to be unresponsive and the family wanted the resident sent to the emergency room. The AP stated she called EMS an hour after talking with the family because she wanted to see what the resident's blood sugar would be.

During an interview, the director of nursing (DON) stated when there is an unresponsive resident, she expects staff to assess the immediate cause and react. The DON stated she expects staff to contact EMS immediately once requested by family. The DON stated the resident went to the hospital and returned no harm done at her baseline.

During an interview, a family member stated it was her expectation for the AP to contact EMS right away after she requested the resident go to the emergency room. The family member stated there was no diagnosis from the incident, and the hospital did not find anything wrong with the resident. The family member stated she felt the resident is safe from blatant abuse and neglect at the facility.

During an interview, a nurse stated he witnessed the AP give orange juice to the resident, and the resident was able to swallow it. The nurse stated the resident was breathing, her eyes were

open, and she turned her eyes to him when he called out her name. The nurse stated the resident was able to follow the command of moving her fingers.

During an interview, the AP stated the resident was able to safely swallow the juice she gave her. The AP stated she would never give juice to a person who could not swallow. The AP stated she called EMS right away after the family requested it.

The resident was not able to complete an interview.

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.
(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care

Vulnerable Adult interviewed: No, unable to interview due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
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
	00955	A. BUILDING: _____ B. WING _____	C 12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY STREET WINONA, MN 55987

(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 #H52336607M and #H52339306M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000	No plan of correction is required for this tag.	

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2 000	Continued From page 1 The following correction order is issued for #H52336607M, 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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual 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 is required for this tag.	