Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53175903M

Date Concluded: June 6, 2023

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Comforcare
1201 17th Street NE
Austin, MN 55912
Mower County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Not Substantiated

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 resident was neglected when the alleged perpetrator (AP) failed to follow the resident's plan of care to use two staff assistance and a EZ stand mechanical lift and transferred the resident alone. The resident became weak, was unable to stand, and fell from the lift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident record indicated the resident was lowered to the floor by the AP to prevent the resident from falling when she became weak and unable to stand. The resident did not sustain a fall or injuries because of the incident. Although the AP failed to use two staff assistance, there is no way to know if the incident could have been avoided with two staff assistance. After the incident an assessment of the resident indicated she required a full body mechanical sling lift for transfers due to weakness.

The investigator conducted interviews with facility staff members, including unlicensed staff. The investigator contacted the resident's family member. The investigation included a review of previous survey documentation including interviews and observations, facility incident and investigation documentation, incident report, interviews/statements, AP disciplinary records, the resident assessments, care plan, and progress notes.

The resident resided in a nursing home with diagnoses including chronic kidney disease, muscle weakness, and congestive heart failure. The resident received hospice for end-of-life care.

At the time of the incident, the resident's care plan indicated she required the use of a EZ stand (standing) mechanical lift and two staff assistance with transfers.

An incident report indicated the resident was getting weak in her legs, arms, and could not hold on to the EZ stand bars while being transferred by the AP alone. The report indicated when the resident started sliding down, the AP lowered the resident to the floor to prevent the resident from falling and potential injuries. When interviewed the resident reported she felt safe, and had no concerns related to her care.

The following day staff completed a mobility assessment for the resident that indicated the resident no longer had the lower extremity strength, stability, and control to safely use the EZ standing mechanical lift, and indicated the resident required a full body mechanical sling lift with a high back sling for transfers.

A progress note indicated the resident's care plan was updated to reflect the resident required two staff assistance and a full body mechanical sling lift with a high back sling for transfers due to the resident's increased weakness.

A communication between facility leadership indicated this was an isolated incident, and the AP had no other disciplinary actions. When interviewed the leadership staff stated it was policy to lower a resident to the floor if they were unable to stand to prevent falling regardless of how many staff assisted.

During an interview, the AP stated the resident required one assist and the EZ standing lift prior to the incident, and she was not informed of any changes in her plan of care. The AP indicated the resident was standing fine, then became weak in her arms and legs, so the AP lowered the resident to the floor to prevent her from falling or getting hurt.

The resident's family stated the resident was lowered to the floor and had no injuries. The family member had no concerns, and indicated the facility and staff provided good care.

In conclusion, 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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP, investigated the incident, reported to the Minnesota Adult Abuse Reporting Center (MAARC). The facility provided coaching and re-education to the AP and staff on safe patient handling techniques including reviewing the plan of care prior to transferring a resident.

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
	00967	A. BUILDING: _____ B. WING _____	C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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 #H53175903M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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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	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	