Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5369090M
Compliance #: H5369083C

Date Concluded: June 4, 2020

Name, Address, and County of Licensee Investigated:
St. Mark's Living
400 15th Ave SW
Austin, MN 55912
Mower County

Facility Type: Nursing Home

Investigator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Inconclusive

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.

Allegation(s):
It is alleged: Abuse occurred when the alleged perpetrator roughly handled a resident while providing cares which resulted in bruises to the resident's legs and perianal area and abrasions to the resident's genitalia.

Investigative Findings and Conclusion:
It was inconclusive whether abuse occurred. While examinations confirmed the resident's injuries, there was conflicting information regarding the cause of the resident's injuries.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement and conducted record review.

The resident was admitted to the facility with diagnoses that included diabetes, macular degeneration, sodium imbalance, and bladder disorder.

Review of the resident's care plan indicated she received assistance with activity involvement, mobility, bathing, dressing, food tray set up, personal hygiene, toilet use, transfers, medication management, fall prevention, pain management, nutrition management, monitoring of skin integrity, bowel and bladder management, and visual function.

Review of a nursing assessment indicated the resident needed extensive assistance with toileting and personal hygiene.

Review of a nurse note approximately two weeks before the date in question indicated the resident had two bruises to her left leg and two bruises to her right leg. The note also indicated the resident had reddened skin in her groin and buttocks and reported pain when these areas were being washed.

Review of a nursing assessment dated six days before the date in question indicated the resident had no areas of skin concerns.

Review of a nursing skin assessment dated four days before the date in question indicated the resident had a healing scab on her left foot; no further skin issues were documented.

Review of a nursing skin assessment dated the evening of the date in question indicated the resident had an abrasion to her perianal area, three bruises to her left leg, six bruises to her right leg and indicated the resident reported pain to her perianal area and left breast.

Review of a nursing skin assessment dated the morning after the date in question indicated the resident reported pain in her perianal area and to her left breast.

Review of staff assignments indicated the alleged perpetrator was assigned to care for the resident during the time in question.

Review of the facility incident report indicated a registered nurse noted blood on the resident's incontinence pad when she went to administer vaginal cream to the resident the evening of the date in question. The report indicated the registered nurse requested an unlicensed staff member to assist and both employees noted scratches on the resident's inner thighs and bruises to the resident's legs. The report indicated that the resident stated a staff member who fit the alleged perpetrator's physical description was rough when performing bedtime cares. The report indicated the alleged perpetrator was suspended and an internal investigation was conducted.

Review of internal investigation indicated interviews of facility residents, interviews of staff members, interview of family members, and skin assessments of facility residents were conducted; as a result, no other issues of unknown skin injuries or concerns regarding the alleged perpetrator were noted. The internal investigation indicated that the resident had long

nails and that the resident reported scratching her genitalia due to the area being itchy. The internal investigation indicated the resident was evaluated the day after the date in question by a medical doctor and due to changes in mental status, the resident was sent to the emergency department for evaluation.

Review of the resident's hospital record indicated the resident was admitted to the hospital the day after the alleged incident and the resident presented with confusion, low sodium levels, low oxygen levels, and a urinary tract infection. The hospital record indicated bruises were present to the resident's legs and perianal area and abrasions were noted to the resident's genitalia. The record indicated the resident told hospital staff members that she had been abused, but was unable to state how. Documentation from a hospital physician indicated the resident had injuries to her genital area that the physician had not seen in the setting of normal hygiene.

During an interview with an unlicensed staff member, she stated when she went into the resident's room to give her medications and the resident was crying and stated that she was hurt by a staff member that fit the alleged perpetrator's physical description. The unlicensed staff member stated the alleged perpetrator was assigned to care for the resident during the shift in question. The unlicensed staff member stated she and the registered nurse both she noted bruises on the resident's legs and a scratch to the resident's genital area, which was reddened. The unlicensed staff member stated the resident had a history of obtaining bruises during use of a mechanical transfer device but during the evening in question, the resident had many purplish bruises, which was unusual for the resident.

During an interview with a facility registered nurse, she stated an unlicensed staff member requested that she look at bruises on the resident's legs. The registered nurse stated she believed the bruises were fresh, had not seen the bruises the previous day, and had not seen bruises like these on the resident's legs in the past. The registered nurse stated the resident claimed a staff member with long fingernails was rough with her during cares and the alleged perpetrator had long fingernails. The registered nurse stated the director of nursing was contacted and the alleged perpetrator was instructed to leave the facility.

During an interview with the director of nursing, she stated she was contacted in the evening by a nurse who told her the alleged perpetrator had been rough with the resident, which caused bruises to the resident's knees and a scratch on the resident's thigh, and that she instructed the registered nurse to suspend the alleged perpetrator. The director of nursing stated she transferred the resident with the mechanical transfer device the day after the date in question and noted that the bruises appeared to have been caused by the mechanical transfer device. The director of nursing stated that the bruises were not all new as they were in different stages of healing and the client had similar bruises in the past. The director of nursing stated the medical doctor assessed the resident and sent the resident to the hospital due to medical concerns regarding the resident's sodium levels. The director of nursing stated she interviewed the alleged perpetrator the day after the date in question and noted that the alleged

perpetrator did not have long nails during the interview nor did it appear that the alleged perpetrator's nails had recently had any salon nails removed.

During an interview with the alleged perpetrator, she stated she cared for the resident during the time in question and had assisted the resident with toileting, changing clothes, and putting the client to bed. The alleged perpetrator stated she had been treated unfairly by staff members at the facility and denied harming the resident.

In conclusion, it was inconclusive whether abuse occurred.

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;
(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;

Vulnerable Adult interviewed: No, family requested vulnerable adult not be contacted
Family/Responsible Party interviewed: No, interview declined
Alleged Perpetrator interviewed: Yes

Action taken by facility: Suspension of alleged perpetrator during internal investigation, internal investigation, reminders to staff members to slow down while providing resident cares and to report any changes in resident condition or new resident conditions to the nurse.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc: The Office of Ombudsman for Long-Term Care
Austin Minnesota Police Department