Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54071564M **Date Concluded:** February 24, 2023

Name, Address, and County of Licensee Investigated:
St. John Lutheran Home
201 South County Road 5
Springfield, MN 56087
Brown County

Facility Type: Nursing Home **Evaluator's Name:** Willette Shafer, 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 perpetrators (AP)-1 and AP-2 neglected the resident when the AP's failed to provide care to the resident according to the resident's care plan, including failing to apply compression socks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. AP-1 and AP-2 reported the incident to the nurse and requested other staff members assist the resident with cares.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's medical record, personnel records, and internal investigation

The resident resided in a nursing home. The resident's diagnoses included anxiety, and congestive heart failure with a recently placed pacemaker. The resident's care plan included assistance with dressing, toileting, and reminders.

According to the internal investigation, the resident reported staff applied her compression stockings and assisted her with cares the day of the incident. The resident reported staff were "rude" to her and reported AP-2 said, "this is why you put your call light on," when the resident requested assistance with removing tray cover. The internal investigation indicated AP-1 assisted the resident on the resident's injured side which caused the resident discomfort.

During an interview, a management staff member said the incident was reported to her by a nurse working during the incident. The management staff said during the internal investigation, AP-2 reported it was a busy day and she didn't mean to sound "rude" to the resident. The management staff said AP-1 denied being "rough" during cares. The management staff said another staff member working with the APs, applied the resident's compression stockings.

During an interview, a staff member said she worked the day of the incident. The staff member said the resident had a recent procedure completed that affected the resident's right side. The resident had her right arm in a sling and reported AP-1 assisted her with cares on her right side which caused discomfort. The staff member denied any visible injuries on the resident's arm.

During an interview, AP-2 said after delivering food trays she answered the resident's call light. AP-2 said the resident requested staff remove her tray cover. AP-2 said she questioned why the resident didn't remove the tray cover herself, so she didn't have to wait to eat. AP-2 said the resident became upset and responded there was no place to set the cover. AP-2 said the resident told her she was being "snippy". AP-2 said she reported this conversation to the charge nurse and requested another staff assist the resident for the rest of the shift as she felt the resident needed some time to calm down and felt a change of staff would be beneficial to the resident. AP-2 said other staff assisted the resident and all cares were completed according to the resident's care plan.

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, deceased.
Family/Responsible Party interviewed: No, declined interview as they had further information to report.
Alleged Perpetrator interviewed: AP-2 was interviewed. AP-1 never responded to interview request.

Action taken by facility:
The facility completed an internal interview. The facility completed re-education and plans of correction.

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
	00045	A. BUILDING: _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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 #H54071564M, 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		