Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56261924M
Compliance #: H56262928C

Date Concluded: November 21, 2023

Name, Address, and County of Licensee Investigated:
Rochester Rehab and Living Center
1900 Ballington Boulevard NW
Rochester MN 55901
Olmsted County

Facility Type: Nursing Home

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, individual responsibility

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:
The alleged perpetrator (AP) neglected a resident when he failed to secure the resident's wheelchair in the van during transport. During transport, the wheelchair tipped over backwards, and the resident hit her head in the van.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP did not follow procedure when he did not secure all wheelchair straps to the van. After the incident, the AP drove the resident to the dialysis appointment and did not report the incident. Dialysis center staff members sent the resident to the emergency room, and she was diagnosed with a hematoma to the back of the head.

The investigator contacted multiple facility staff for interviews. The investigation included review of the resident's record, facility policies and procedures, and van driver staff training records, including the AP's training record. The investigator also reviewed investigation

summaries and interviews completed shortly after the incident occurred by the facility and the federal survey team.

The resident resided in a skilled nursing facility (nursing home). The resident's diagnoses included recent surgical repair for femur fracture, heart disease, end stage kidney disease and dialysis dependent. The resident was also on anti-coagulant therapy (blood thinning medication). The resident's care plan indicated she traveled by wheelchair in the transport van to dialysis appointments three times a week. The resident's assessment indicated she was oriented and cognitively intact.

The dialysis NP (nurse practitioner) note indicated the resident reported to dialysis staff that on the way to dialysis she had fallen backwards in the wheelchair and hit her head against the floor or side of the bus during transport and the wheelchair was apparently not secured properly. The assessment indicated the NP could feel a posterior occipital hematoma. The note further indicated NP was reluctant to proceed with hemodialysis until the resident was further evaluated in the emergency room to rule out a brain bleed in the setting of blood thinning medication.

The resident's nursing assessment completed the day after the incident indicated the resident had bruising and slight swelling on the side of her head, and shoulder bruising.

The facility corrective action summary for the AP indicated the facility investigated an unreported resident incident on the bus (transport van) in which the resident hit her head during transport.

The AP's employee training transcript dated several days after the incident, indicated he enrolled in online "Incident Reporting in Behavioral health" training.

The AP's statement written after the incident indicated the straps were properly secured before leaving the facility. The same document indicated he heard the resident's voice and heard the straps loosen, then resecured the straps after he pulled over off the road.

During an interview, the life enrichment director (LED) verified the facility transport van was verified by a local company, which found the security straps were in good working condition with no indication of equipment malfunction and concluded the event stemmed from operational error. The LED stated this indicated that if the resident would have been strapped in securely, the wheelchair would not have been able to tip over.

The resident was interviewed and stated the front straps were not fastened. She stated the van went up a big hill, she started to roll back, and yelled for help. She stated the concern was that she hit her head and was on blood thinning medication. The resident's family member stated she was notified of the incident when she received a call from the dialysis staff that the resident would not receive dialysis today and needed to go to the ER.

The facility policy, “Volunteers of America national services Driving Safety Program, revised 11/4/2019, indicated all vehicular accidents, regardless of severity, must be reported immediately to the employee’s direct supervisor and an incident report completed.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP did not return the request for interview.

Action taken by facility:
After the incident, the facility provided retraining of all van driver staff on transport policies and the policy for reporting incidents. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, 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

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.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Olmsted County Attorney
Rochester City Attorney
Rochester Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29822	A. BUILDING: _____ B. WING _____	C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CI	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(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 #H56261924M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	No plan of correction is requried for this tag.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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2 000	Continued From page 1 #H56261924M, 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 reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an indivdual alleged perpetrator was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		