

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56284621M
Compliance #: H56284724C

Date Concluded: October 14, 2024

Name, Address, and County of Licensee

Investigated:

MN Veterans Home - Silver Bay
56 Outer Drive
Silver Bay, MN 55614
Lake County

Facility Type: Nursing Home

Evaluator's Name:

Jana Wegener, 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 a resident when they failed to follow the resident's plan of care causing the resident to fall out of bed and sustain injuries requiring transfer to the emergency department (ED).

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident fell and sustained injuries while the AP was assisting the resident with cares. The residents care plan was inconsistent on the number of staff required to assist the resident with cares. The AP was implementing the residents plan of care as directed. The AP was not responsible for neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), hospital records, facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in a skilled nursing facility with diagnoses including multiple sclerosis, and spastic hemiplegia.

The resident's plan of care indicated the resident required 2 person assist with turning and repositioning in bed. For mobility the care plan included EZ way smart lift assist with 2 person assist or the ceiling lift with 1 person assist. The care plan also indicated the resident needed 1 to 2 person assist with bathing and personal hygiene.

An incident report indicated the AP was performing incontinence cares for the resident and rolled the resident toward herself causing the resident to roll off the bed onto the floor. The incident report indicated the resident sustained a head strike with a hematoma, complained of left wrist/hand pain, and had bruising on his toes. The resident was sent to the ED for evaluation.

The hospital ED discharge summary indicated the resident sustained a contusion of the right forehead and pretibial right leg. The resident's right lower leg x-ray was negative for any acute fracture or traumatic abnormality. A CT scan of the resident's head and neck were also negative for any acute traumatic injuries.

A review of the facility investigation documentation indicated the resident was care planned for one person assist transfer using a ceiling lift, and two person assist with a Hoyer lift. The resident was care planned to need one person assist with repositioning in bed because he had the ceiling lift in his room which could be utilized for repositioning. The investigation indicated the level of assistance the resident required was not consistent on the resident's care plan. When interviewed the AP and other staff members stated that they thought that the resident needed assistance of one or two persons with cares. The facility investigation includes interviews with staff, some stated they thought the resident required 1–2-person assistance with cares and bed mobility. The investigation indicated the AP thought the resident needed assistance from one or two persons with cares. The AP stated when she rolled the resident toward herself the resident's body spasmed causing him to fall off the bed onto the floor.

During email communication and interview with facility leadership indicated when the AP and other staff were interviewed, they identified the care plan was unclear which had caused confusion about the level of care the resident needed. The resident's care plan was updated to include clear instructions and staff were re-educated following the incident.

When interviewed the AP denied any wrongdoing and stated she thought she was following the resident's plan of care at the time the incident occurred.

When interviewed the resident's family member stated the resident received great care at the facility and he had no concerns of neglect.

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: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility investigated the incident, identified the care plan was unclear, updated the care plan with clear instruction, and re-educated staff to prevent recurrence.

Action taken by the Minnesota Department of Health:

No further action taken.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2024
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NAME OF PROVIDER OR SUPPLIER MINNESOTA VETERANS HOME - SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 56 OUTER DRIVE SILVER BAY, MN 55614
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(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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H56284621M/# H56284724C in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.</p>	2 000	<p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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