Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5631014M
Compliance #: H5631012C

Date Concluded: January 20, 2021

Name, Address, and County of Licensee Investigated:
MN Veterans Home Luverne
1300 North Kniss
Luverne, MN 56156
Rock County

Facility Type: Nursing Home

Investigator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, individual responsibility

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: The alleged perpetrator (AP) neglected the resident when she failed to use a gait belt when walking the resident to the bathroom. The resident experienced a fall that resulted in a subdural hematoma (brain bleed), occipital bone fracture (bone at the base of the skull), and death.

Investigative Findings and Conclusion:
Neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to use a gait belt and failed to provide assistance while bringing the resident to the bathroom. The resident fell, sustained a subdural hematoma and non-displaced occipital bone fracture. The resident died the same day directly as a result of the fall.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, and the resident's family. The investigation included an interview with the AP. The investigation included review of the resident's medical record, hospital record,

death record, internal investigation, and policy and procedures related to gait belt use and assistance with ambulation. Finally, the investigation included a review of the AP's employee file and training records.

The resident's medical diagnoses included dementia, osteoporosis, stroke, vision and hearing loss. The resident's Minimum Data Set (MDS) indicated the resident had moderate cognitive impairment and required extensive assistance of one staff for bed mobility, transfers, walking on the unit, dressing, toileting, and personal hygiene. The residents Care Area Assessment (CAA) indicated the resident was at risk of falls due to balance problems and unsteadiness when moving from sit to stand positions. The residents care plan indicated he had impaired mobility due to history of a stroke. He was able to walk short distances with assist of one staff, a walker, and a gait belt. The care plan also indicated he was taking Plavix (blood thinning medication).

One morning, the AP assisted the resident with morning cares. The AP did not apply the residents gait belt and left the resident unattended to open the bathroom door. The resident took a couple steps and fell straight backwards from a standing position. The resident struck the back of his head on the floor. The AP and the other nurse aide in the room were unable to reach the resident in time to stop the fall. The nurse assessed and noted a lump at the base of his skull, vital signs and neurological status noted as stable at that time. Approximately 30 minutes later the resident complained of head and low back pain. Staff observed the resident rubbing the top of his head and followed commands of squeezing hands. The resident received Tylenol (pain medication) and the nurse applied an icepack. Approximately two hours later, the resident received Tylenol again and observed as "sleepy" and did not wake enough for neurological checks or follow commands of squeezing the nurse's hands. The residents blood pressure noted as 120/86, pulse 113 (normal 60-100), oxygen saturation (SpO2) was 92% (normal 95-100), and temperature 96.9 degrees Fahrenheit. Approximately two and half hours after that, the resident attempted to throw his legs out of bed. The nurse assisted the resident to sit up at the edge of bed, provided Tylenol, and the resident ate some cereal. Shortly after eating, the resident began gagging and spitting up. The resident's oxygen saturation decreased to 70% and he had an upper airway gurgle. Staff sent the resident to the emergency room. The emergency room diagnosed the resident with a subdural hematoma and non-displaced occipital bone fracture. The resident returned to the facility the same day on comfort care and passed away.

The resident's death record indicated the immediate cause of death was intracranial hemorrhage with one-day onset to death. The same document also indicated pneumonia with two to three day onset to death.

The resident's hospital record indicated the resident diagnosed with a brain bleed, occipital bone fracture, and status post emesis (vomit) likely early aspiration pneumonia. The same document indicated that with very aggressive treatment that included surgical intervention and then ventilator care the resident might survive but with a poor outcome. In addition, the same

document indicated the family elected to transfer the resident back to the facility on comfort care.

The facility's internal investigation indicated the director of nursing (DON) interviewed both the AP and the other nurse aide in the room at the time of the fall. The internal investigation indicated the AP did not apply a gait belt.

During an interview, the DON stated she conducted an internal investigation of the fall. She stated the AP assisted the resident with morning cares and brought him to the bathroom. The DON stated the AP did not apply a gait belt. She stated it was approximately 10 feet from the bed to bathroom door. She stated the AP reported she walked next to the resident and stepped ahead of him to open the bathroom door. She stated the AP turned around and the resident fell straight backwards. She stated neither the AP nor the other nurse aide in the room could not reach the resident in time to break the fall. She added the root cause of the fall focused on lack of gait belt use. The DON stated the AP was aware the resident required a gait belt for transfers and ambulation. She also stated the AP did receive discipline for not following the care plan. In addition, the DON stated the resident did not have a recent history of falls and the last fall occurred five months prior to the incident.

During an interview, a certified nursing assistant (CNA) stated she was in the room and witnessed the residents fall. She stated she was assisting the resident's roommate at the time of the fall. She stated the AP provided morning cares and left the resident unattended to open the bathroom door and turn on the light. She stated the distance from the resident's bed to the bathroom door was approximately 11 or 12 feet. She stated the resident got up and walked three or four steps using his walker towards the bathroom door while the AP was ahead of him. She stated the resident fell straight back, hit his head on the ground, and his walker fell on top of him. She stated she could not reach him in time to break the fall nor could the AP. She stated after the fall she stayed with the resident for about a half hour and the resident developed a lump at the base of his head. She stated the resident required one staff assist using a gait belt and walker for ambulation and transfers.

During an interview, the AP stated that she assisted the resident with morning cares on the day of the fall. The AP stated she did not apply a gait belt. The AP stated she walked ahead of the resident to open the bathroom door. When she turned around the resident was in the process of falling and she could not reach him in time to break the fall. She stated she did not use a gait belt that day because she got busy doing other things and he usually walked fine in the mornings. The AP stated the resident required a gait belt when transferring or walking.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

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

Action taken by facility:
The facility nurse assessed the resident, provided updates to the family, and sent the resident to the emergency room for evaluation. The facility conducted an internal investigation.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Rock County Attorney
Luverne City Attorney
Luverne Police Department