Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL25816050M
Compliance #: HL25816051C

Date Concluded: February 7, 2020

Name, Address, and County of Licensee Investigated:
MS-AC Mankato AG Senior Living
118 Raven Court
Mankato, MN 56001
Blue Earth County

Name, Address, and County of Housing with Services location:
Autumn Grace II
110 Raven Court
Mankato, MN 56001
Blue Earth County

Facility Type: Home Care Provider

Investigator's Name: Laura DuCharme
Special Investigator

Finding: Substantiated, facility 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 facility and the alleged perpetrator (AP) neglected the client when the AP failed to transfer the client in a safe manner resulting in a fall with fractures.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client's plan of care did not clearly specify how to transfer the client so it was left to the discretion of the unlicensed personnel which led to an unsafe transfer resulting in the client's leg fractures.

The investigation included interviews with the family, facility staff members, and therapy staff. In addition, the investigator reviewed the client's medical records, the AP's personnel file, facility internal investigation notes, and facility policies. The investigator also observed transfers of clients at the facility.

The client's diagnoses included arthritis, bipolar disorder, anemia, leg edema, anxiety, chronic back pain, chronic kidney disease, diabetes, left and right shoulder pain, Parkinson's disease,

bursitis in the left hip, osteopenia (bone weakening), and a history of rotator cuff repair and hip fracture repair. According to the client's service plan, the client was dependent on staff for bathing, dressing, transferring, toileting, and grooming. The client had mild cognitive deficits but was able to make her needs known.

Review of the client's most recent care plan indicated staff were instructed to transfer the client with one or two staff members assisting using a transfer belt and EZ Stand (brand name of a mechanical lift) "at times." The client's most recent vulnerability assessment indicated the client had a history of falls and was able to transfer safely with the use of a walker for steadiness and use of the rails and bars in the restroom and tub room. Staff were instructed to monitor the client for signs of unsteadiness and fatigue. The assessment contained no information about the use of the EZ Stand.

Review of the client's physical therapy evaluation note indicated that staff reported the client had a functional decline and required the use of the EZ Stand for all transfers and noted the client had not walked in the previous month. The evaluation further noted the client experienced severely reduced standing and dynamic standing balance and shortness of breath with minimal exertion. The therapy discharge summary indicated the client refused further therapy services as the staff refused to walk her. Staff used the EZ Stand to transfer her.

Approximately two months later, the client was hospitalized for pneumonia and four days later returned to the facility with two medication changes. There was no evidence in the client's record that the client was reassessed after her hospitalization to determine her transfer needs. Later that night while assisted to the bathroom by the AP, the client became weak and could not stand so the AP lowered the client to the floor. The AP assisted the client alone with only a grab bar available to assist the client. The client immediately experienced pain in her left leg and was later diagnosed with a left distal and proximal fracture (broken left leg). The client was hospitalized and did not return to facility.

During an interview, a family member stated the client was very weak and unable to bear her own weight; therefore, she required a mechanical lift to transfer but staff would often not have time or a second person available to use the lift so they would lift her under her arms.

Staff interviews revealed there was no consistency or direction given regarding the safest way to transfer the client. Some staff insisted the client could only transfer with the mechanical lift at all times with two staff assisting; yet, several others stated they were instructed to transfer her with one staff assisting, a gait belt, and grab bars in the bathroom.

During interview, the AP indicated she was taught to transfer the client in the bathroom using the grab rails and to do whatever she needed to do to get the job done.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No. The client was unavailable for interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility is currently under new management and updated policies related to care plans and transfer assessments have been put in place to correct the lack of clarity and direction to staff.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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, 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.

cc:
The Office of Ombudsman for Long-Term Care
Alternative Solutions
Blue Earth County attorney
Mankato City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H25816	A. BUILDING: _____ B. WING _____	C 01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS-AC MANKATO AG SENIOR LIVING LLC	118 RAVEN COURT MANKATO, MN 56001

(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
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 6, 2020 the Minnesota Department of Health initiated an investigation of complaint #HL25816051C/#HL25816050M. At the time of the survey, there were 22 clients receiving services under the comprehensive license. The following correction order is issued for #HL25816051C/#HL25816050M, tag identification 0325.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of three clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On February 3, 2020 the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) is required. Please refer to the maltreatment public report for details.	