Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358337745M
Compliance #: HL358334622C

Date Concluded: October 6, 2023

Name, Address, and County of Facility Investigated:
Comforting Angels
202 Highway 10
Hawley, MN 56549
Clay County

Facility Type: Home Care Provider

Evaluator's Name: James Larson, RN
Special Investigator

Finding: Not Substantiated

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):
An unlicensed staff member/ alleged perpetrator (AP) neglected the client when they attempted to transfer the client using a mechanical lift without proper training, resulting in injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The staff member/alleged perpetrator (AP) was trained by the agency nurse in proper transfer techniques with the use of a mechanical lift and the client's plan of care was followed at the time of the incident. Although the client sustained minor injuries, the injuries were documented and assessed by the facility nurse. Following the transfer, the client complained of pain, was assessed by the agency nurse, and sent to the hospital for an evaluation.

The investigator conducted interviews with agency staff members, including unlicensed personnel, and nursing staff. The investigator also interviewed the client's family. The

investigation included review of the client's medical record, nursing assessments, service plans, and progress notes.

The client received home care services in her home. The client's diagnoses included paraplegia, venous thrombosis (blood clots), and embolism. The client's service plan included for staff assistance with activities of daily living, including transfers with the use of a mechanical lift.

Complaint documents indicated during a transfer of the client from her bed to a chair, the client was not well positioned on the mechanical lift and the client complained she could not breathe. The client's improper alignment resulted in her body shifting inside the lift harness before the transfer was completed. This change in position caused the client's legs to be drawn up and the harness support strap pinched the client, resulting in a bruise on her upper chest. In addition, the client began bleeding from a ruptured external hemorrhoid.

During an interview with a nurse from the agency, the nurse recalled being notified of an incident involving the client and the AP that resulted in injury. The nurse made an unscheduled visit to the client's home to assess the client and advised the client to seek further orthopedic assessment due to a new complaint of knee pain. The nurse also inspected the lift equipment and found no functionality issues or need for repair.

During an interview with the unlicensed staff member/alleged perpetrator (AP) who completed the transfer, the AP recalled the initial attempt to transfer the client was unsuccessful. The client was not well positioned in the lift and reported to the AP they could not breathe. The AP immediately set the client back on the bed, repositioned the client, and made a second attempt to transfer the client. The AP indicated the second transfer attempt was successful and did not recall the client sustaining any injury. When questioned about training, the AP stated they received on-the-job instruction on the proper operation of the client's mechanical lift from the agency nurse.

During an interview with the client, she stated the AP previously provided care and was familiar using the mechanical lift equipment. The client indicated the mechanical lift was in working order and was not in need of repair of any kind at the time of incident. The client described once she was fully lifted off the bed and suspended in the air, her body shifted, and her knees were drawn up to her chest. The client immediately notified the AP she was not able to breathe in this position and the AP immediately returned her to the bed. The client recalled the AP stating they saw blood underneath the client when the AP repositioned the sling for another transfer attempt. The client explained to the AP bleeding had happened in the past, when an external hemorrhoid ruptured, during a transfer with another caretaker. The AP then repositioned the client and completed a successful transfer of the client without further incident.

Shortly after the incident, the client complained of knee pain and was brought to urgent care for further evaluation. The client was told she strained her medial knee ligament (MCL) and if the pain persisted, to seek further orthopedic care. The client did not seek further care.

During an interview with the resident's family member, they indicated they were aware of the services the client received and the incident involving the mechanical lift. The family recalled that the client was seen for a follow up visit, although no further treatment was indicated. The family had no concerns with the care the resident received, however, stated the client no longer received services from the agency.

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 AP was provided additional training on proper mechanical lift transfer techniques.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	H35833	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTING ANGELS	202 HIGHWAY 10 HAWLEY, MN 56549

(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, these correction orders are issued pursuant to a complaint investigation. 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: #HL358334622C/HL358337745M #HL358334573C/HL358337765M On September 11, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were an unknown number of clients receiving services under the provider's Comprehensive license. The following correction orders are issued for #HL358334573C/HL358337765M, tag identification 1075. No correction orders were issued for HL358334622C/HL358337745M.	0 000	Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	

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01075	Continued From page 1	01075		
01075 SS=D	144A.4794, Subd. 2 Access to Records The home care provider must ensure that the appropriate records are readily available to employees or contractors authorized to access the records. Client records must be maintained in a manner that allows for timely access, printing, or transmission of the records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the appropriate records were available and maintained in a manner that allowed for timely access for one of one clients (C5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: The licensee failed to provide requested records for C5 and attempts to contact owner (O)-A were not successful. On September 19, 2023, at 1:20 p.m., the phone number listed on the licensee's website for their Hawley, Minnesota office was called, the number was not in service. The investigator called O-A on her personal cell phone and left a voicemail requesting a call back	01075		

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01075	Continued From page 2 to discuss the investigation. O-A did not call the investigator back. On September 19, 2023, the investigator emailed O-A a request for C5's medical record for the following information: Signed Service Plan Individual Abuse Prevention Plan Evidence of client receipt of Minnesota Home Care Bill of Rights ACH Authorization Form Admission paperwork/contract signed by client/representative. Admission Nursing Assessment Nursing assessments Nursing Notes /Progress notes Billing invoices Staff schedules for client visits Documentation of services provided. Documentation of Services Missed/ Unable to Provide Service dates. Evidence of invoices sent to client/ representative. As well as copies of: Admission Policy Service Contract Policy Staffing and Scheduling Policy Individual Abuse Prevention Plan Policy Contract Termination Policy Provider unable to provide service/ missed visit Policy Billing Policy Refund Policy A reply with all the requested information was to be submitted by 4:30 p.m. CST Friday, September 22, 2023. O-A did reply to the email in an email stating, "Due to the circumstances, your time frame is unreasonable". None of the records	01075		

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01075	Continued From page 3 request were sent within the required timeframe. After additional phone conversations it was agreed the investigator would meet office personnel at the Hawley, MN office on September 28, 2023, at 1:00 p.m. to retrieve the requested records. No further information was provided. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS.	01075		