

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202208056

Date Issued: February 15, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

West Central Community Services
114 11th Avenue SE
Elbow Lake, MN 56531

West Central Community Services
401 8th Street North
Breckenridge, MN 56520

License Number and Program Type:

1113517-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070074-HCBS (Home and Community-Based Services)

Investigator(s):

Scott Broady
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
scott.broady@state.mn.us
651-431-6557

Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) arrived at a hospital with several areas of bruising and an open wound on his/her coccyx. The VA had fractures of his/her fibula, tibia, and clavicle. The VA was treated for a urinary tract infection (UTI), sepsis, dehydration, and low blood pressure.

Date of Incident(s): September 28, 2022

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 2, paragraph (b), clause (1); and subdivision 17, paragraph (a):

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

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 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 which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on October 10, 2022; from documentation at the facility, law enforcement records, and medical records; and through interviews conducted with four facility staff persons, the VA, the VA's guardian, and a hospital health care professional.

The facility was a single level wheelchair accessible home. The main level included a living room, dining room, and a kitchen. There was an L shaped hallway off of the living room. Off of the immediate hallway there was a laundry room, a bathroom, and at the corner of the hallway the VA's bedroom. Around the corner of the hallway were three more bedrooms (one other consumer lived at the home) and a bathroom where the VA took a shower.

The VA's diagnoses included a moderate intellectual disability and dementia. The VA's support plans included the following information:

- The VA required supervision by a staff person while in the community and required a staff person to be in the facility at all times.
- The VA had poor circulation. Staff persons were to monitor the VA for signs of breakdown or circulation concerns. Staff persons were to schedule needed medical appointments for the VA.
- The VA was able to communicate his/her wants and needs to others. It took the VA time to process questions and the VA responded slowly but was able to indicate his/her opinion of preference.
- The VA ambulated with the use of a wheelchair. The VA was able to move short distances, but was mainly depended on staff persons to get him/her places around the facility. The VA used a Hoyer lift for transfers. The VA had a history of falling out of his/her wheelchair and rolling out of bed. The VA had bed rails on his/her bed. The VA used a shower chair to shower. There was no information regarding supervision requirements in the bathroom.
- The VA enjoyed being outside in nice weather and visited parks, community events, and parades.

A staff person (P2) provided the following information in a staff person communication log, a facility *Incident Report and Review*, and in an interview conducted jointly by this investigator and a law enforcement officer. On September 28, 2022, P2 arrived at 8 p.m. and the staff person (P3) working said that the VA had fallen in the shower and that P3 was currently icing both of the VA's shins. After P3 left, P2 went to check on the VA and at that time, his/her eyes were wide open, his/her mouth was wide open, and his/her color was "very pale." The VA was not responding to P2. P2 checked the VA's blood pressure which was 111/66 and called a supervisory staff person (P1) who advised P2 to call a facility health care professional (HCP4) and take the VA's blood oxygen levels. The VA's blood oxygen levels were initially 88 and 89% on different hands and then 84 and 79% on different hands. P2 spoke to HCP4 with an update and HCP4 told P2 to call 9-1-1. The VA was transported to the hospital. Before the VA went to the hospital, P2 noticed bruising on the VA's shins, but the rest of the VA's body was covered up. P2 did not have any concerns with the VA the night before.

Hospital records stated the following:

- On September 28, 2022, the VA arrived at the emergency room. The VA had low blood oxygen saturation. The VA had stool stuck to his/her bottom and skin breakdown on the scrotum and buttocks. The VA's initial diagnoses were urinary tract infection with sepsis, altered mentation, low levels of oxygen, and bruising of the shins.
- The VA was subsequently diagnosed with a right tibia-fibula fracture, a left proximal tibia fracture, and a right clavicle fracture.

A law enforcement report stated:

- On September 29, 2022, the LEO went to a hospital in response to concerns about the VA. A hospital health care professional (HCP1) told the LEO that the VA had bruising on his/her chest and multiple bruising and scabbing on his/her right shoulder. There was significant bruising on the VA's right shin below his/her knee, fractures to the right and left tibias and fibulas, a right clavicle fracture, as well as skin breakdown and open sores on his/her buttocks and groin area. When the VA arrived at the hospital, the VA had an incontinent brief that was soaked and contained hard packed feces.
- On October 4, 2022, the LEO spoke with the VA in the hospital and the VA stated that "everyone" treated the VA "fairly," but no other information was obtained from the VA.

On October 10, 2022, this investigator interviewed the VA while the VA was in the hospital. The VA answered some yes and no questions, but did not provide information pertinent to the investigation.

Regarding the VA's initial diagnoses of urinary tract infection with sepsis, altered mentation, low levels of oxygen:

The police report stated that on September 29, 2022, the LEO contacted P1 who told the LEO that the VA was incontinent and his/her brief was to be changed regularly. The VA also had hard stools. The VA had a history of having sores on his/her buttocks which had always been an issue as they healed and then reappeared.

P1 provided the following information in an interview conducted jointly by the LEO and this investigator:

- The VA wore incontinent briefs that were changed several times a day. At night the VA was unable to use the toilet on his/her own and at night used a catheter.
- The VA had ongoing issues with a sore on his/her coccyx. If staff persons noticed the area to start to open the VA had a patch that was prescribed that staff persons could use to cover the sore. The VA had an air mattress bed and there was no requirement that the VA needed to be repositioned in bed unless the VA asked to be repositioned. There was no set amount of time that the VA could be in his/her wheelchair. The VA would let staff persons know if s/he wanted to get out of the wheelchair.
- The VA would “go and go” with activities and then be tired and “crash” for a couple of days. The VA was a good drinker in “spurts” and drank juice. Staff persons tried to get the VA to drink water, but the VA wanted to drink pop. The VA always had a glass of water by him. The VA was able to drink out of glass without assistance.

P2 told this investigator and the LEO that s/he worked overnights at the facility and typically arrived at 8 p.m. P2 typically checked on the VA every three hours unless s/he requested assistance. P2 was not aware of any pressure sores on the VA. On September 26, 2022, P2 worked with the VA and did not notice anything out of the ordinary with the VA.

P3 provided the following information in an interview conducted jointly by the LEO and this investigator:

- The three days prior to the VA’s hospitalization, the VA had many activities and outings that s/he attended and it was typical after active days for the VA to be tired and have a “crash day.” The VA drank a lot pop, but occasionally drank water. The VA also drank juices.
- The VA had a pressure sore on his/her bottom that opened up once in a while. If the sore opened up, there was a medical patch that staff persons were to place on the sore.

An Incident Report and Internal Review stated after the VA was taken to the hospital, P3 was contacted to see how the VA was during the day and P3 said that the VA was tired, but P3 believed that it was from activities.

P4 provided the following information in an interview conducted jointly by the LEO and this investigator:

- P4 said that on the three days prior to the VA’s hospitalization, the VA had “busy days” outside of the facility and that it was warm outside. The VA liked to drink pop and the VA was encouraged to drink more liquids other than pop, but it was difficult to have the VA drink liquids other than pop. P4 said that s/he did not “push” the VA to drink water during that time. The VA ate well.
- The VA had a recurring pressure on his/her buttocks. P4 said that staff persons took “pretty good care of it” and P4 was not aware of it being open at the time of the VA’s hospitalization.

In the staff person communication log on September 20, 2022, P3 documented that the VA’s sore on his/her

bottom was showing again (P4 also signed the entry). There was no other information in the communication log or the VA's progress notes regarding the sore on the VA's buttocks.

The VA's progress notes from September 21 through September 26, 2022, stated:

- Between September 21 and 26, 2022, there were no concerns noted with the VA.
- On September 22, 2022, P3 documented that the VA went fishing and had a bonfire with P3 and P4. The VA was "very talkative" and was "smiling, laughing, joking."
- On September 23, 2022, there was no documentation.
- On September 24, 2022, P3 documented that the VA went to a local community center for a pancake breakfast.
- On September 25 and 26, 2022, there was no documentation.

Regarding the fractures to the VA's legs:

The bathroom that the VA used to shower had a roll in shower. The shower had grab bars, but all of the grab bars were above the VA's waistline. Otherwise, the shower had three flat walls. There was a standard toilet next to the shower. On the opposite wall of the toilet was a vanity that was open underneath.

The VA's shower chair had a metal frame with a plastic seat resembling a toilet seat. The chair had four small wheels. It had arm rests on either side. There was a gap between the seat and the back of the chair which was fabric. There was a Velcro strap that went across the VA's waist.

In the internal review report, P3 and P4 provided the following information about the VA's shower:

On September 27, 2022, [P3] and [P4] were on. [P3] went to supply shop. [The VA] was quite sleepy that day and [P4] thought [s/he] would give [the VA his/her] bath at one of [his/her] waking moments. [The VA] had been on several community activities and will often be tired for a few days after. [The VA] was not happy about [his/her] shower, but [P4] felt [his/her] shower was important due to [his/her] peri care and skin care. [P4] had two towels in the bathroom as is [his/her] usual. [The VA] seemed quite cold and was shivering after the shower so [P4] left the room to the adjacent laundry room to get a towel to cover [the VA] with. It only took a short time. When [P4] returned, [s/he] immediately saw [the VA] in front of [his/her] chair with [his/her] feet under [him/her] and one knee on the tile floor with the safety belt keeping [him/her] suspended. [P4] went to [the VA] and put [his/her] hands and arms up on [P4's] shoulders. [P4] put [his/her] arms around [the VA's] chest and lifted [him/her] into the chair. [P4] then returned [him/her] to the bedroom and [s/he] said that [the VA] complained of pain when touching two areas where there was redness and swelling. When [P3] returned, they looked at [the VA's] legs and put ice to the area and elevated [his/her] legs. They gave [the VA] Tylenol for pain. [The VA] ate [his/her] usual dinner and seemed to be tired so [s/he] went to bed. In the morning the swelling had went down and there was bruising. [The VA] did indicate

some pain when pressure was put on the areas. The remainder of the day, [the VA] was tired and slept but did not seem in further pain.

P4 provided the following information in an interview conducted jointly by the LEO and this investigator:

- On the day that P4 gave the VA a shower, the VA was recovering from three days of outings and was acting "off." P4 was not scheduled to work that day, but s/he came to the facility because s/he was in the area. (P4 said that s/he typically went to the facility on his/her days off to help P3 take consumers to do activities in the community.)
- When P4 arrived, P3 was working and P3 left to go grocery shopping. P4 gave medications to the VA, the VA had a normal bowel movement, and then P4 gave the VA a shower. At that time, the VA was "irritable" and just wanted to sleep. P4 gave the VA a shower as usual and gave the VA two towels to dry off. After the shower, there was more water on the floor than usual so P4 went to grab more towels from another area of the facility.
- When P4 returned with the towels, the VA was sitting at the end of the shower chair was hanging by the Velcro strap and the shower chair was in the upright position. (P4 demonstrated that the shower chair had two wheels in the shower and two wheels out of the shower with the VA facing a shower wall and the toilet next to the shower when P4 left to get the towels.) P4 said that the VA's right leg was bent with the toes back touching the floor and the left leg was in an upright position. P4 wrapped a towel around the VA and "bear hugged" him/her to get him/her back into the chair. P4 checked the VA's head and all joints and observed a "goose egg" on each knee cap. P4 provided ice and ibuprofen to the VA. P4 never saw the VA on the floor of the bathroom. P4 did not see bruising on the VA's chest after the incident.
- After P3 returned from shopping, P4 stayed about 30 minutes and then left. During that time the VA appeared to be "very groggy."
- P4 typically gave the VA his/her showers, but P3 was usually at the facility in case P4 needed assistance. There was no requirement that two people had to be at the facility when the VA showered and P4 was told that the VA did not require two staff persons to do transfers. When P4 was asked why s/he decided to give the VA a shower while P3 was gone, P4 said that the VA was struggling and tired so P4 thought s/he would "jump start" the VA's day by giving him/her a shower.
- P4 gave inconsistent information about when s/he documented the incident and P4 did not fill out an incident report the day of the incident.
- At that time of the initial interview, P4 was not aware of the extent of the injuries to the VA's legs or shoulder. P4 said that s/he did not cause any injuries to the VA.
- P4 received training specific to the VA. P4 explained the Hoyer transfer and the sling that was used with the VA. P4 described the shower chair as being "very big and bulky" and that the VA "sinks" into the chair. The shower chair had a Velcro belt that was hard to use and that staff persons complained about the belt.

P3 provided the following information in an interview conducted jointly by the LEO and this investigator:

- The day of the incident, P3 went grocery shopping and when s/he returned, P4 told him/her about the VA's fall. (P3 said that s/he was the only staff person scheduled to work that day, but P4 came to the facility and supervised the VA while P3 went and bought some groceries.) When P3 saw the VA, the VA had redness on his/her shins, but no bruising. P3 elevated the VA's legs, placed ice on the VA's legs, and did not see any swelling of the legs. P4 told P3 that s/he checked for head injuries and did not see any. P4 left the facility about 90 minutes after P3 arrived back at the facility. P3 did not question the fall and believed that the VA slipped forward in the shower chair. Neither P3 nor P4 called P1 or a facility health care professional. P3 believed that the VA fell on September 26, 2022, and was taken to the hospital the following night.
- For the remaining of P3's shift, the VA was quiet and resting. When P2 arrived to the overnight, P3 told P2 about the fall and documented the fall in the VA's progress notes. The next day, P3 was told that the VA had low pressure and looked "dead" and went to the hospital. Prior to the interview, P3 was not aware of the extent of the VA's injuries.
- The VA did not like to take showers. When the VA showered, the VA was transferred via Hoyer lift to his/her bed, undressed, and then transferred into a shower chair using the Hoyer lift. Two staff persons were to assist the VA when using the Hoyer lift. After the VA showered the routine would be reversed. The shower chair used by the VA had a strap that went across the waist of the VA and was the only thing keeping the VA in the shower chair. The shower chair also tilted back.
- P3 and P4 "managed" the facility together. P3 said P4 typically showered the VA, but P3 assisted P4. While P4 would shower the VA, P3 would gather supplies such as towels. Two staff persons typically were working when showering the VA, but P3 was not aware that P4 was going to give the VA a shower that day. Staff persons were not to leave the VA unattended in the shower and P3 would have not left the VA alone in the bathroom in the shower chair. P3 was not aware of any other time were the VA was given a shower without a second staff person in the facility.
- P3 did not cause any of the injuries to the VA. P3 received training specific to the VA and the use of the Hoyer lift.

The law enforcement report stated:

- The VA's case manager (CM) told the LEO that the VA took a shower on September 27, 2022, and fell and then was lifted back in his/her chair by a staff person. The CM stated that one staff person was working, but there should have been two staff persons to shower the VA and to lift the VA up off the floor.
- The LEO talked to a hospital health care professional (HCP2) who "suggested" that the fall was "hard" due to spiral fracture. The fall had to have happened with "force." Falling out of a wheelchair or shower chair would not cause the injuries.

This investigator talked to another hospital health care professional (HCP3) who treated the VA, and HCP3 told this investigator the fracture and bruising to the VA's left leg was worse than the right leg. HCP3 believed that the fractures were not the result of a twist. The VA's legs looked like a bar hit across both legs at the same spot or the VA might have ran into a something like a chair.

P2 provided the following information in an interview conducted jointly by the LEO and this investigator. P2 never gave the VA a shower. Prior to the incident, P2 was not aware of the VA falling in the shower. P2 received training specific to the VA including the use of the Hoyer lift. P2 did not cause any injuries to the VA.

The LEO conducted a follow up interview with P4 in which P4 provided the following information:

- The LEO told P4 that the VA sustained serious injuries that were not consistent with the VA's fall as explained by P4.
- P4 said that it was common for him/her to go to the facility on his/her days off. With only one staff person working it was difficult to get the VA and the other consumer out so P4 would assist the staff person working to take them out of the facility. (Both P3 and P4 stated that P4 went to the facility when not working, but the facility provided documentation that on September 27, 2022, P4 worked from 12 to 5:30 p.m.)
- On the day of the fall, P4 arrived to visit around noon. P3 was working and told P4 that the VA was not having a good day, the VA was lethargic and tired. P4 stated that the three days prior to the fall, the VA went to P3's and P4's home and spent four to five hours outside in the yard. P3 and P4 each thought it was because the last three days the VA was outside away from the facility. It was typical for the VA to rest the day after going out on activities. Prior to that day, the VA followed a typical routine after waking up in the morning. The day of the fall, the VA had a hard time following the routine. When P4 arrived the VA had been through the morning routine of breakfast, medications, and using the bathroom. It was not typical for P4 to be with the VA without other staff persons when s/he was not working, but P4 agreed to stay so P3 could go grocery shopping.
- After P3 left, P4 thought the VA needed a shower as it had been a few days and that it might help make the VA feel better. The VA was typically showered in the morning once or twice a week. The VA brief was changed twice a day unless the VA had a large loose bowel movement which happened often. Two staff persons typically were involved with showering the VA with P4 assisting the VA with the shower, while P3 would hand towels to P4. P4 left the VA in the shower to get more towels and when s/he returned observed that the VA slid forward in the shower chair and the strap was the only thing keeping the VA from being face down on the floor.
- After the shower, P3 returned and P4 left and did not document the fall. P4 was asked about the date of the fall as the communication log was not written by P4 and the date was written out of chronological order of the dates before and after it. P4 was not sure the date of the fall.
- P4 said that the VA did not receive any injuries while at P3's and P4's home.
- The LEO told P4 that it appeared that several protocols were not clear or not followed and P4 agreed with the LEO.

In the staff person communication log, on September 27, 2022, (the entry was initially dated September 28, 2022, and was between two entries dated September 28, 2022), P3 documented that the VA fell in the shower and had

minor bruising on his/her "knee/calf/shin." The VA was in bed to alleviate pressure on his/her lower legs.

In the VA's progress notes, on September 27, 2022, P4 documented about the VA's fall and on September 28, 2022, P2 documented about the VA's condition and that s/he was taken to the hospital.

In the police report, the LEO stated that it was unclear from notes on the communication log and verbal reports from P1, P2, and P3 whether the fall occurred on September 26, 27, or 28, 2022. It was unknown if P4 logged the fall in the shower as the dates were misleading. The LEO also stated that s/he was unsuccessful in his/her attempts to contact P3 for a follow up interview (P3 no longer worked at the facility).

P1 provided the following information in an interview conducted jointly by the LEO and this investigator:

- Prior to the incident, the facility had one staff person working with two staff persons scheduled for activities. After the incident, the facility scheduled two staff persons to work at a time. The VA was to be in visual or auditory range of staff persons at all times. Prior to the incident, there was nothing in the VA's support plans regarding how many staff persons were to be working when the VA took a shower. It was preferred that two staff persons were working so the second staff person would be in the facility if needed. There was no requirement that a staff person had to be with the VA in the bathroom and there no prior incidents with the VA in the bathroom. The VA was showered twice a week and given bed baths in between. The VA did not like showers.
- P1 did not see the VA during the week prior to him/her going into the hospital. P1 believed that the VA might have received the injury to his/her shoulder and bruises on his/her chest from the incident in the shower chair. At that time of the interview, P1 did not know the details of the injuries to the VA's legs.
- P1 said that s/he should have been notified about the fall, but was not notified.

An administrative staff person (P5) went through the facility looking for any possibility where the VA could have hit his/her legs. At that time, the VA's personal belongings had already been removed from the facility. P5 provided the following information regarding what s/he believed could have been possibilities for the VA to injure his/her leg:

- The VA had a recliner and the VA's legs could have caught between the foot rest and the chair when closing the chair.
- The facility had a wheelchair accessible van with a ramp that needed to be lowered manually that could have hit the VA's legs as it was being lowered to the ground.
- The vanity in the bathroom had a board underneath that was below hip level and the VA's legs could have been pushed into the board.
- The VA had a metal hospital bed and the VA could have been pushed into one of the railings. The height of the bed and the VA's wheelchair would have had to each been in a certain position.
- Other than the recliner in the living room, there was nothing in the common area that looked like it could have caused an injury. The VA's wheelchair fit underneath the kitchen table. There were only flat surfaces in

the shower.

Regarding the injuries to the VA's shoulder:

The VA had a Hoyer lift which was raised and lowered with a switch. It had an arm that extended out with a bracket that pivoted 360 degrees with hooks at each end where a sling attached. To transfer the VA, a sling was placed underneath the VA with four corner straps that attached to the arm of the lift.

In the internal review report, P3 and P4 provided the following information about the VA's shoulder:

I asked [P3] about the injury on [the VA's] shoulder. [P3] indicated that it occurred on September 22, 2022. [P3] was not aware of it at the time, but was made aware of it the next morning when [P4] asked how [the VA] got red spot and bruising to [his/her] right shoulder. [P3] indicated that the night before as [s/he] was putting [the VA] to bed and [s/he] thinks that [the VA] may have gotten it from the metal part of the Hoyer lift as [the VA] said ouch when [s/he] was getting [him/her] out of the lift. [P3] said that [s/he] did not check for an injury due to [the VA] often saying ouch when using the lift. [P3] said that the metal part had come in contact with [the VA] so they felt it caused the injury. [The VA] had no complaint about the shoulder and did not indicate pain. [The VA] had [his/her] usual range of motion and use of the arm. [P4] gave the same recount of the situation with the arm.

P3 told this investigator and the LEO that on September 22, 2022, the sling that was used to lift the VA from the bed to the Hoyer lift caught the VA's shoulder and the VA said, "Oww." The VA said, "Oww," if anything touched the VA. P3 did not see marks on the VA's shoulder from that incident and P3 believed that the bruising on the VA's shoulder was from the shower incident.

In the staff person communication log, on September 23, 2022, P4 documented that the VA had a red abrasion on his/her right shoulder (this was the first documented concern about the VA's shoulder).

In the staff person communication log on September 24, 2022, P3 documented that the VA's shoulder bruise was looking better.

There was no information in the VA's progress notes between September 21 and 28, 2022, regarding the VA's shoulder.

The VA's guardian (G) stated that prior to the VA's hospitalization, s/he did not have concerns about the care that the VA received at the facility.

Facility documentation showed that P2 - P4 each reviewed training specific the VA, the use of the Hoyer lift, and on the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

Hospital records stated the following:

- On September 28, 2022, the VA arrived at the emergency room. The VA had low blood oxygen saturation. The VA had stool stuck to this/her bottom and skin breakdown on the scrotum and buttocks. The VA's initial diagnoses were urinary tract infection with sepsis, altered mentation, low levels of oxygen, and bruising of the shins.
- The VA was subsequently diagnosed with a right tibia-fibula fracture, a left proximal tibia fracture, and a right clavicle fracture.

It should be noted that the VA was admitted to the hospital the evening of September 28, 2022. Although information from staff persons and documentation was not clear, September 27, 2022, was the most likely the date that the VA fell in the shower as the VA did not go in for medical treatment the night of the incident.

Regarding the VA's initial diagnoses of urinary tract infection with sepsis, altered mentation, low levels of oxygen:

P2 stated that on September 28, 2022, P2 arrived at 8 p.m. and P3 told P2 that the VA had fallen in the shower and that P3 was currently icing both of the VA's shins. After P3 left, P2 went check on the VA and at that time, his/her eyes were wide open, his/her mouth was wide open, and his/her color was "very pale." The VA was not responding to P2. P2 checked his/her blood pressures which was 111/66 and the VA's blood oxygen levels recorded between 79 and 89 different hands. P2 called 9-1-1. P2 said that s/he did not have any concerns with the VA the night before.

P3 and P4 each stated that the VA spent time outside and engaged in activities for a few days prior to his/her hospitalization. Information showed that the VA did not always drink water. Information also showed that it was common for the VA to be tired after being involved in activities. P4 first noted that the VA was tired on September 27, 2022, prior to his/her shower. P2 did not have any concerns about the VA that night. Other than the fall reported by P4, there was no other information that the VA was not feeling well other than being tired or sore from the fall prior to P2 being concerned about the VA and calling 9-1-1.

Information also showed that the VA had an ongoing issue with a pressure sore and there was a medication available if needed. In the staff person communication log on September 20, 2022, P3 documented that the VA's sore on his/her bottom was showing again, but there was no other information in the communication log or the VA's progress notes regarding the sore on the VA's buttocks.

Although the VA was diagnosed with sepsis, altered mentation, low levels of oxygen, given that the first documentation of the VA being tired was on September 27, 2022, prior to his/her fall in the shower, that there was no information that the VA had symptoms of these diagnoses prior, and that after P2 had concerns about the VA's health, medical attention was sought for the VA, there was not a preponderance of the evidence whether there was a failure to obtain timely medical care for the VA.

Regarding the fractures to the VA's legs:

On September 27, 2022, P4 arrived at the facility and P3 left to go shopping. P4 decided to give the VA a shower

as P4 thought the VA needed a shower as it had been a few days and that it might help make the VA feel better. After the VA's shower, the VA seemed cold and shivering so P4 left the VA in the shower chair to get the VA a couple more towels. When P4 returned to the bathroom, s/he observed that the VA slid forward in the shower chair and the strap was the only thing keeping the VA from being face down on the floor. At that point, the VA was at the front of the shower chair with his/her feet under him/her and one knee on the tile floor with the safety belt keeping him/her suspended. P4 went to the VA and put his/her hands and arms up on P4's shoulders. P4 put his/her arms around the VA's chest and lifted him/her up into the chair.

P4 then returned the VA to the bedroom. P4 checked the VA's head and all joints and observed a "goose egg" on each knee cap and s/he said that the VA complained of pain when touching two areas where there was redness and swelling.

When P3 returned, they looked at the VA's legs and put ice on the area and elevated his/her legs. They gave the VA Tylenol for pain. The VA ate his/her usual dinner and seemed to be tired so s/he went to bed. In the morning, the swelling had went down, but there was still bruising. The VA did indicate some pain when pressure was put on the areas. The remainder of the day, the VA was tired and slept but did not seem in further pain.

After being diagnosed, the injuries to the VA did not appear to be consistent with the fall in the shower that P4 described. HCP2 "suggested" to the LEO that the fall was "hard" due to spiral fracture and the fall had to have happened with "force." Falling out of a wheelchair or shower chair would not cause the injuries. HCP3 told this investigator that s/he believed that the fractures were not the result of a twist. The VA's legs looked like a bar hit across both legs at the same spot or the VA might have ran into a something like a chair.

Although the descriptions of what might have caused the VA's injuries from HCP2 and HCP3 were not consistent with each other, neither explanation matched what P4 said happened. It was likely that the injuries occurred in the bathroom or in the time frame immediately surrounding the shower, but without any witnesses other than P4 to what happened, it was not determined how the VA received the fractures to his/her legs.

Prior to the incident, it was facility practice to have two persons present in the facility when the VA took a shower even though one person gave the VA a shower. There was no information in the VA's support plans that the VA required two person present to take a shower.

Whether the VA's leg injuries occurred during the fall in the bathroom or any other manner, without knowing what caused the injuries to the VA's legs, there was not a preponderance of the evidence whether the injuries were caused by means other than during the provision of therapeutic conduct or whether they were caused by a failure to provide the VA with reasonable and necessary supervision.

Regarding the VA's shoulder:

After being diagnosed with a right clavicle fracture, HCP1 told the LEO that the VA had multiple bruises and scabbing on his/her right shoulder.

P3 provided information that on September 22, 2022, when P3 transferred the VA to bed, the VA's right shoulder hit the metal part of the Hoyer lift and the VA said, "Oww." At that point, P3 did not look for an injury and the VA did not complain of pain. The VA had his/her usual range of motion.

In the staff person communication log, on September 23, 2022, P4 documented that the VA had a red abrasion on his/her right shoulder (this was the first documentation with a concern about the VA's shoulder) and on September 24, 2022, P3 documented that the VA's shoulder bruise was looking better. There was no information in the VA's progress notes between September 21 and 28, 2022, regarding the VA's shoulder.

Although the VA hit his/her shoulder on September 22, 2022, and there was documentation the next two days about an injury, there was no documentation or information from staff persons that the VA's shoulder had multiple bruises and scabbing prior to going to the hospital. However, that did not rule out the VA injured his/her shoulder at that time. In addition, it was not determined how the VA received the injuries to his/her legs as the explanations for those injuries were not necessarily consistent with what happened in the bathroom so it was possible whatever happened to cause the injuries to the VA's legs could have played a role in causing the injury to the VA's shoulder.

Because it was not determined when it happened or the circumstances that caused the injury to the VA's shoulder, there was not a preponderance of the evidence whether the injuries were caused by means other than during the provision of therapeutic conduct or whether they were caused by a failure to provide with the VA reasonable and necessary supervision.

It was not determined whether physical abuse occurred (conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult).

It was not determined whether neglect occurred (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 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 which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were not adequate, but followed. The facility updated the VA's support plan to include that a staff person was to remain in the bathroom with the VA when the VA was showering.

Action Taken by Department of Human Services, Office of Inspector General:

No further action taken.