DEPARTMENT OF HUMAN SERVICES

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: 202209436

Date Issued: March 31, 2023

Name and Address of Facility Investigated:

Lutheran Social Service of Minnesota
5502 22nd Ave NW
Rochester, MN 55901

Lutheran Social Services of Minnesota
2485 Como Ave
Saint Paul, MN 55108

Disposition: Inconclusive

License Number and Program Type:

1116276-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069963-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that during the overnight shift on November 12, 2022, a vulnerable adult (VA) fell near his/her bedroom at the facility. A facility resident (R1) told a staff person (SP) that the VA fell, but the SP left the VA on the floor for an unspecified amount of time before s/he was assisted from the floor when another staff person (P1) arrived at the facility. The VA was later diagnosed with a fracture in his/her left foot.

Date of Incident(s): Prior to November 13, 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 17, paragraph (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 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 December 14, 2022; from documentation at the facility and the VA's medical records; and through interviews conducted with facility staff persons (P1 and P2), two facility residents (R1 and R2), and the VA's guardian (G). This investigator met the VA and another facility resident but they were nonverbal and were not interviewed. Two letters, one certified, were sent to the SP requesting an interview with this investigator, but the SP did not respond. However, according to P2, a supervisory staff person, the SP provided information to him/her, and it is included below.

Facility documentation showed that the VA was diagnosed with seizures and a developmental disability and had an unsteady gait which affected his/her mobility. The VA walked with assistance from staff persons and used a wheelchair and a gait belt to travel longer distances. The VA was often incontinent of urine and wore an adult brief. When staff persons assisted the VA to take a shower, s/he sat in a shower chair. Spending time with his/her family members and the G was one of the VA's preferred activities.

Facility documentation, the VA's medical records, information provided in interviews with this investigator, and the facility's *Internal Review*, provided the following information:

P1 said that when s/he arrived for his/her shift shortly after 8 a.m., on November 13, 2022, the VA was lying on the floor with the lower half of his/her body inside his/her bedroom and the upper half of his/her body supported by a pillow, in the hall outside the bedroom. The SP (who had worked from 10 p.m. to 8 a.m.) was standing in the doorway of bathroom with an adult brief in his/her hand. The VA was wearing a loose pullover garment that covered his/her body to about the mid-thigh but was not covered with a blanket and was not wearing an adult brief, which s/he usually wore when s/he slept. The VA was clean and dry, had not become incontinent of urine, seemed happy, and was laughing. However, P1 was concerned and assessed the VA, but did not see any injuries to the VA. P1 and the SP lifted the VA from the floor into his/her bed and put an adult brief on him/her.

P1 asked the SP why the VA was on the floor, and the SP replied that shortly before P1 arrived, the VA slipped to the floor when the SP was helping the VA with personal hygiene after the VA used the bathroom. The SP was unable to lift the VA from the floor and was about to put a brief on him/her when P1 arrived. The SP's shift was over, and s/he left the facility, but the VA ate breakfast and engaged with P1 as s/he usually did. At 11 a.m., R1 awoke and told P1 that s/he saw the VA lying on the floor at 2 a.m. when s/he went to the bathroom during the previous overnight shift. R1 said that the SP was in a chair in the living room, so s/he told the SP about the VA. The SP stated that s/he would "take care" of the VA but did not assist the VA from the floor. P1 thought that R1's account of the incident was correct because R1 "did not know how to lie." R2 saw him/herself as a caregiver to the VA and was protective of him/her but had a history of providing inaccurate information.

R1 told this investigator that during an overnight shift on a date s/he could not recall, s/he saw the VA lying on the floor, crying, when R1 exited his/her bedroom to go to the bathroom. The VA was wearing pajamas. R1 told the SP, who was in the living room watching television, about the VA, and the SP said that s/he could not get the VA "up." R1 then returned to his/her bedroom.

On a morning of a date R2 could not recall, R2 saw the VA lying on the floor. It was still dark outside, and the SP was asleep in the living room in a chair. R2 usually got up several times during overnight shifts to get snacks, so it was not uncommon for him/her to leave his/her bedroom during overnight shifts.

Documentation from P2 and information that the SP provided in the *Internal Review* showed that at 7:55 a.m. on November 13, 2022, the SP and P2 talked by phone, but the SP did not mention that the VA was lying on the floor. At 8:10 a.m., P1 arrived for his/her shift, found the VA lying on the floor, and told P2 what s/he saw. P2 then asked the SP about the incident, and the SP said that on the morning of November 13, 2022, s/he assisted the VA to take a shower and began drying the VA off after the shower. The VA then "slipped out" of the shower chair, and the SP attempted to move the VA from the floor but was unable to do so. P2 said that the SP should have immediately notified him/her of the incident to obtain help to get the VA off the floor or called the non-emergency phone number for a law enforcement agency if P2 was unavailable. It was possible that the SP fell asleep during his/her shift, but prior to the incident, there were no concerns regarding the SP's work.

After the incident, staff persons monitored the VA for possible injuries. On November 15, 2022, the VA had swelling/bruising to his/her left ankle and was taken to the emergency department of a hospital for evaluation.

The VA's medical records showed that on the afternoon of November 15, 2022, the VA was evaluated at the emergency department of a hospital for left ankle swelling. On the previous Sunday, the VA fell in in the bathroom at the facility. Additional details regarding the fall were "unknown," but the VA acted normally after the fall and did not complain of pain or have bruises. On November 15, 2022, the VA's left ankle was swollen, and s/he was brought to the hospital. The physical examination of the VA showed that his/her left ankle was "significantly" swollen when compared to the right one, but no redness was noted. X-rays of the left ankle found that the VA had a small bone spur, and it was "suspect" that an acute avulsion fracture of the talus (the bone in the lower part of the ankle joint) caused the swelling of the VA's left ankle. The VA was given a "walking boot" to stabilize and protect his/her ankle and it was recommended that s/he be as non-weight bearing as possible. The VA was instructed to take over the counter pain reliever for pain, to elevate and "ice" his/her ankle, and to return to the emergency department if his/her symptoms worsened.

The facility's personnel and training records showed that staff persons interviewed for this report were trained on the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

Conclusion:

Information was consistent that on the morning of November 13, 2022, the VA was lying on the floor near his/her bedroom when P1 arrived for his/her shift. P1 observed the VA on the floor and the SP standing in the bathroom doorway, holding an adult brief.

P1 said that the VA was wearing clothing that covered him/her to the mid-thigh, but the VA was not covered with a blanket or wearing an adult brief. The VA seemed happy and was laughing, was not incontinent of urine when P1 arrived, and had no observable injuries.

The *Internal Review* showed that the SP and P2 spoke by phone at 7:55 a.m. on November 13, 2022, but the SP did not mention concerns with the VA. Later, when P2 asked the SP about the VA, the SP said that on the morning of November 13, 2022, when s/he was helping the VA to dry him/herself after a shower, the VA "slipped out" of the shower chair onto the floor. The SP attempted to move the VA but was unable to do so.

P2 said that the SP should have contacted a supervisory staff person or called a law enforcement agency for assistance. In addition, there were concerns that the SP slept during his/her shift.

Staff persons monitored the VA for injuries, and on November 15, 2022, the VA had swelling of his/her left ankle. The VA was evaluated at the emergency department of a hospital and had an acute avulsion fracture of the talus bone, which was stabilized with a walking boot. Staff persons were given instructions to care for the VA, and s/he returned to the facility.

It was unknown whether the VA was on the floor at 2 a.m. on November 13, 2022, or slipped onto the floor moments before P1 arrived later that morning, and whether the SP slept during his/her shift. It was also unknown how the VA sustained a fracture to his/her left ankle. However, the VA was frequently incontinent of urine, but was clean and dry when P1 arrived at 8 a.m., seemed happy and was laughing when assisted from the floor, and had no signs of injury until two days later. Given this, and that the facility immediately sought care for the VA when it became aware that s/he was injured, there was not a preponderance of the evidence whether there was a failure to provide the VA with care or services that were reasonable or necessary to obtain or maintain the VA's health or safety.

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* which determined that its policies and procedures were adequate, but not followed. The SP did not notify a supervisory staff person about the incident and might have slept during his/her overnight shift at the facility. The facility retrained its staff persons on emergency reporting and procedures, the Maltreatment of Vulnerable Adults Act, and the expectation that staff persons remain awake during all shifts. When this report was written, the SP no longer worked at the facility.

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

No further action taken.