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: 202409481

Date Issued: February 12, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive.

Dungarvin Minnesota, LLC
621 Lower Johnson Cir
Saint Peter, MN 56082

Dungarvin Minnesota, LLC
1440 Northland DR STE 100
Mendota Heights, MN 55120

License Number and Program Type:

1120684-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) had an unexplained gaping wound on his/her left leg. The VA was evaluated at the emergency department of a hospital (hospital A) and diagnosed with hematomas, then transferred to another hospital (hospital B) for additional care.

Date of Incident(s): November 2, 2024

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 4, 2024; from documentation at the facility and medical records; and through interviews conducted with facility staff persons (P1, P2, SP1, SP2, and SP3), and the VA's guardian (G). Two letters, one certified, were sent to another staff person (SP4), but s/he did not respond to the letters or attempts to contact him/her electronically.

Facility documentation including the VA's *Coordinated Services and Supports Plan* (*CSSP*), and *Emergency Data Form* showed that the VA was diagnosed with arthritis, paranoid schizophrenia, and porphyria. Porphyria referred to a group of disorders that resulted from buildups of natural chemicals in the body. Porphyrins were needed to make heme, which was a part of hemoglobin, a protein in red blood cells that carried oxygen to the body's organs and tissues. When the levels of porphyrins were unbalanced, there might be problems with the nervous systems and skin. Symptoms of acute porphyria might include severe pain in the belly, chest, legs or back, muscle pain, tingling, numbness, weakness or paralysis, mental confusion, sudden painful skin redness and swelling, or fragile thin skin with changes in skin color.

The VA had difficulty recalling information and had a history of leaving the facility without telling staff persons where s/he was going. The VA used a wheelchair for mobility and staff persons used a shower chair, portable commode, and mechanical lift with a sling to assist the VA with mobility inside the facility, and the VA had an oxygen concentrator but used portable oxygen tanks on community outings. The VA's left kneecap was dislocated, and the mechanical lift was to be used each time the VA was transferred. The VA required assistance from staff persons for all activities of daily living and staff persons verbally encouraged the VA to assist with activities if s/he could. The VA was upbeat and had a good sense of humor.

Interviews with this investigator, the VA's medical records, facility documentation, and the facility's *Internal Review*, provided the following:

- P1 documented that on the morning of November 2, 2024, s/he arrived for his/her shift at the facility and assisted the VA with breakfast, then noticed that there was blood on the floor near the VA's leg. In an interview with this investigator, P1 said that s/he observed a small amount of blood on the back of the VA's leg and asked SP1, who was working with him/her, to check on the VA's leg. SP1 checked and told P1 said that it looked like there was a skin tear on the back of the VA's left leg. SP1 bandaged the VA's leg and left the facility when his/her shift ended at about 9 a.m.

- P1 said it was not unusual for the VA to have skin tears, but at lunch time the VA told P1 that his/her left hip hurt, and P1 noticed that the leg was swollen and had bruises on the lower leg, so s/he called an on-call supervisory staff person who instructed P1 to call 9-1-1. The VA was transported to the emergency department of hospital A via ambulance. P1 checked the VA's adult absorbent undergarment several times before lunch, but it was dry and P1 did not notice the bruises until the VA complained of hip pain. P1 thought that the VA's leg might have been scraped when s/he was transferred and denied that s/he caused the VA's injuries.

- SP1 stated in an interview with this investigator that on the morning of November 2, 2024, P1 and SP1 noticed that the VA's leg was bleeding. SP1 assessed the VA, but it was difficult to see the back of the VA's leg because the VA's legs did not fully straighten. SP1 viewed the VA's left leg from the side, wiped blood away from back of the leg, applied an antibiotic cream, and bandaged it with an adhesive wrap. The VA's leg was bruised, but bruises were not uncommon for the VA and SP1 thought that the bruises on the VA's leg were previously documented. The VA did not voice concerns regarding his/her leg to SP1 or say that s/he had pain. According to SP1, the VA had fragile skin that sometimes sloughed off in patches, which was what SP1 thought had happened. SP1 had no idea of the extent of the VA's injuries, or s/he would have immediately taken the VA to a hospital.

- According to SP1, the VA's health deteriorated over recent years, and s/he often declined to complete the physical therapy exercises that his/her health care team recommended and slowly his/her mobility decreased. Staff persons had to provide greater assistance to the VA. The VA had an adjustable bed, and s/he gradually walked less, first using a walker and then a wheelchair. Staff persons transferred the VA using a manual pivot transfer or a mechanical lift, but it was difficult to maneuver the lift in the facility because it was not set up for accessibility. There was an electric mechanical lift, but when the VA was discharged from hospice care, the electric lift was taken away, and the lift that was at the facility was larger and more difficult to use. SP1 was unsure how the VA was injured and said that the VA was "alert and fine" on November 2, 2024, when SP1 left the facility.

- A *General Event Report* (*GER*) and the VA's medical records from hospital A, showed that on November 2, 2024, the VA's left leg was bruised from the hip to the ankle and was very swollen. The VA complained of pain and had two large hematomas on his/her upper left thigh and the left side of his/her abdomen. The VA's hemoglobin and hematocrit levels were low, and s/he required a blood transfusion. In addition, there was a cut on the back of the VA's left calf that was about two inches long, and about a half an inch deep. The cut was bleeding when the VA arrived at the hospital, and the VA did not recall what happened to his/her left leg.

- A physical examination showed that the VA had no obvious signs of trauma or tenderness to his/her head, but there were possible deformities to his/her left hip and left knee, with tenderness to touch on the left lateral and anterior hip with extensive bruising to the lower left leg, groin, and torso, and mild bruising to the VA's right collarbone area. Photographs taken at hospital A showed the VA's injuries, and the bruises on the right collarbone area were faded and a different color than the bruises on the VA's leg and torso. The skin on the VA's legs looked very dry and flaky in the photographs. X-rays of the VA's left leg showed no fractures or breaks, and a computerized tomography (CT) scan of the VA's left hip showed no acute fracture or malalignment. There were some arthritic degenerative changes to the VA's joints, and s/he had a dislocated left kneecap. The VA was medically stabilized and transferred to hospital B for possible additional treatment of his/her injuries.

- Medical records from hospital B showed that on November 2, 2024, the VA was evaluated there and found to have a pelvic hematoma, left thigh hematoma, lower left leg laceration, and contusions to his/her right arm, left leg, and groin. There was possible active bleeding within the pelvic hematoma and the hospital contacted the G regarding treatment options for the VA, but the G wanted the VA to have comfort measures only because the VA had not been "doing well" and his/her health was in decline. At

hospital B, the VA had difficulty eating and was given a pureed diet and was not to be left unsupervised with food. The G wanted the VA to be discharged to a skilled nursing facility (SNF) that could meet his/her needs on hospice care. Several SNFs declined to admit the VA, but hospital B located an SNF that agreed to care for the VA, and s/he was discharged to it on November 11, 2024.

- SP2, a supervisory staff person, said in an interview with this investigator, that s/he did not see the VA's injuries but was aware that the VA was transported to hospital A on November 2, 2024. Because SP2 worked day shifts, the VA was often clothed when SP2 saw him/her. However, at about 8 a.m. on the day before the VA went to hospital A, SP2 assisted the VA to take a shower and helped the VA get dressed after the shower and saw "nothing out of the ordinary." The VA was prone to skin tears and the skin on his/her arms was very thin, but SP2 was unaware of concerns with the skin on the VA's legs. On November 1, 2024, SP2's shift ended at about 5:30 p.m., and SP3 worked the shift after SP2's, then was followed by SP1 and P1.

- According to SP2, staff persons transferred the VA by having the VA wrap his/her arms around them, lifting the VA into a standing position, pivoting with the VA, and lowering him/her. The VA could be transferred with the mechanical lift. However, the lift did not fit into the bathroom, so staff persons could not use it when they moved the VA into and out of the shower/bathroom. SP2 thought that P1 transferred the VA with a two-person pivot transfer, or the lift, and SP1 transferred the VA without assistance using a one-person pivot transfer. Staff persons who worked the overnight shifts would not usually move or transfer the VA. SP2 thought that staff persons completed good documentation regarding the needs of the VA and other facility residents, and s/he had no concerns with their work at the facility.

- SP3 said that s/he worked evening shifts and every other weekend at the facility. When SP3 transferred the VA between his/her wheelchair, recliner, and bed, s/he manually lifted the VA by placing his/her arms under the VA's "armpits," lifted the VA to a standing position, turned with the VA, and gently lowered the VA into his/her chair or onto his/her bed. The facility had a mechanical lift that could be used to transfer the VA, but the VA did not feel comfortable in the lift and preferred that staff persons manually assist him/her to stand, pivot, turn, and sit. SP3 saw the VA on the evening shifts of the week prior to November 2, 2024, when s/he assisted the VA with hygiene tasks, and the VA had no injuries. SP3 said that the facility's bathroom was small, and s/he was unsure whether the mechanical lift would fit into it. SP3 denied that s/he caused the VA's injuries.

- SP4 did not respond to interview requests, but according to P2, who was an administrative staff person, and the facility's *Internal Review*, SP1, SP2, SP3, and SP4 each acknowledged that they transferred the VA manually, but each knew that the VA should be transferred with a mechanical lift. It was unknown how the VA was injured.

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

Relevant Rules and or Statutes

Minnesota Statutes, section 245D.07, subdivision 1a stated that the license holder must provide services in response to the person's identified needs, interests, preferences, and desired outcomes as specified in the support plan and the support plan addendum.

Conclusion:

The VA's diagnoses included porphyria, which might cause the VA to have pain, tingling, numbness, weakness or paralysis, mental confusion, painful red skin and swelling, or fragile thin skin with changes in skin color. The VA used a wheelchair for mobility. There was a mechanical lift which was to be used to transfer the VA according to P2.

Information was consistent that during the morning shift of November 2, 2024, P1 and SP1 became aware that the VA had an injury to the back of his/her left calf that bled onto the floor. SP1 cleaned the back of the VA's calf, applied antibiotic cream, saw what s/he thought was a skin tear, and bandaged it with an adhesive wrap, but did not fully see the injury since the VA's legs did not completely straighten. SP1's shift ended, and s/he left the facility. It was not unusual for the VA to have skin tears, but at lunch the VA told P1 that his/her left hip hurt and s/he noticed that the VA's left leg was swollen and bruised. P1 called 9-1-1 and the VA was evaluated first at hospital A, then at hospital B. The VA was unsure how his/her leg was injured.

Medical records from the hospitals showed that the VA had left lateral and anterior hip tenderness with extensive bruising to the lower left leg, groin, and torso, mild bruising to the VA's right collarbone, and a lower left leg laceration. The bruises on the VA's collarbone were faded and a different color than the bruises on the VA's leg and torso. The VA had no fractures or breaks, and no malalignment of the hip, but his/her left kneecap was dislocated. The G wanted the VA to be discharged to an SNF for comfort measures because the VA's health was recently in decline, and on November 11, 2024, the VA was discharged from hospital B to the SNF.

SP2 said that s/he did not see the VA's injuries and the VA was often clothed during his/her shifts. On November 1, 2024, SP2 assisted the VA to take a shower and helped him/her get dressed but saw no injuries. There were no concerns with the skin on the VA's legs, but s/he was prone to skin tears. Staff persons transferred the VA manually by standing and pivoting or with the mechanical lift, but it did not fit into the bathroom. SP2 had no concerns regarding staff persons' work at the facility.

SP3 transferred the VA manually and did not use the mechanical lift because the VA did not feel comfortable in it. The week prior to November 2, 2024, SP3 worked evening shifts with the VA, but s/he saw no injuries to the VA and denied that s/he caused the VA's injuries. SP4 did not complete an interview with this investigator.

Information from P2 and the VA's plans showed that mechanical lifts were to be used when the VA was transferred but SP1, SP2, SP3, and SP4 provided information in the *Internal Review* that they transferred the VA using a manual pivot transfer which was a violation of Minnesota Statutes, section 245D.07, subdivision 1a. However, information was consistent that the mechanical lift did not fit into the bathroom and there was no information that the VA's injuries occurred while being transferred. Given that SP1 provided first aid to the VA when s/he knew that the VA's calf was injured, that when the VA complained of pain and P1 further evaluated s/he called 9-1-1, that the VA had thin skin that was prone to skin tears and that it was unknown when or how the VA's injuries were sustained, there was not a preponderance of the evidence whether there was a failure to provide the VA with care or services that were necessary to obtain or maintain the VA's health or safety.

It was not determined whether neglect occurred (he 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 their policies and procedures were adequate but were not followed. Staff persons did not document the VA's injuries according to policy and did not seek immediate medical care for the VA. Staff persons were retrained on documentation, reporting procedures, and first aid. In addition, SP1, SP2, SP3, and SP4 received a disciplinary action because they transferred the VA using a pivot transfer and did not transfer the VA with a mechanical lift.

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

The facility was not issued a Correction Order for the violation outlined in this report because they took corrective action.