Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52185825M **Date Concluded:** November 8, 2023

Name, Address, and County of Licensee Investigated:
Mayo Clinic Health System Lake City
500 West Grant Street
Lake City, MN 55041
Wabasha County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), facility staff, neglected the resident when they failed to ensure the resident was transferred safely using an EZ way mechanical standing lift, and transferred the resident when she was unable to participate. As a result, the resident fell from the lift and sustained a head laceration which required staples.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. A preponderance of evidence showed the AP was responsible for the maltreatment when they failed to follow the resident's plan of care which instructed staff to adjust levels of care to meet the resident needs, use two staff to transfer the resident when weak, and ensure proper placement of the harness safety belt prior to transferring to prevent injury. The AP transferred the resident independently using the mechanical standing lift when the resident was lethargic and not responding normally. The resident fell from the lift and was sent to the hospital with a head laceration which required staples.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a EZ way lift representative and the resident's family. The investigation included review of resident assessments, incident notes, progress notes, care plan, Kardex, staff schedule, staff training/competency, EZ way manufacturers guidelines, facility investigation documentation, staff statements, lift inspection documentation, facility policies/procedures, and initial survey documents and interviews.

The resident resided in a nursing home with diagnoses including chronic kidney disease with heart failure, weakness, and history of falling.

The resident's assessment prior to the incident indicated the resident had moderate cognitive impairment due to dementia and could sometimes understand and make her needs known. The resident required extensive assistance from staff with activities of daily living including transfers, dressing, and toileting. The resident's assessment indicated the resident was at risk for falls due to a history of falling related to problems with intermittent confusion, balance, standing, walking, and required assistive devices for mobility.

The resident's care plan at the time of the incident indicated the resident was at risk for falls and required assistance from one to two staff using a EZ stand mechanical lift for transfers. The care plan instructed staff to notify the nurse immediately if the resident was not tolerating one assist.

The resident's Kardex at the time of the incident indicated the resident required extensive assistance from one staff and may need two staff assistance as needed. The Kardex instructed staff to adjust the level of care provided to meet the residents needs during times of weakness and ensure proper placement of the EZ stand harness and safety belt prior to transferring the resident to prevent injury.

An email communication from facility nursing staff to facility leadership indicated the AP reported the resident slipped out of the EZ stand harness and fell. The resident was transferred to the emergency department for evaluation and treatment of her head injury.

A handwritten statement by the AP following the incident indicated prior to the transfer the AP noticed the resident was not responding normally to communication and just looked at the AP. The AP noted the resident was unable to place her feet on the EZ stand platform which was different from the resident's normal behavior. The AP indicated she had to physically assist the resident to place her feet onto the EZ stand platform, which was unusual for the resident, but she thought the resident was just tired. The AP indicated she was unsure if the resident was too weak for the EZ stand. The AP documented as the resident was lifted, she noticed something started to slip, and stopped the machine to bring it down, but it was too late, and the resident fell.

The facility investigation indicated when interviewed by facility leadership the AP stated the resident was lethargic at the time of the transfer, and as the AP lifted the resident up the EZ stand harness slid down the residents back and the resident fell to the floor hitting the back of her head. The AP stated she knew how to find information on the resident's Kardex and care plan. When asked by leadership staff if the resident was lethargic why was the EZ stand lift instead of the full body lift, and the AP did not know why. The EZ stand was taken out of service and inspected with no concerns found.

The facility investigation findings report indicated the resident was transferred using the EZ stand when another form of transfer should have been used due to resident weakness. The report indicated the AP used the EZ stand when the resident was not physically able to participate effectively. The AP reported the resident had notable difficulty raising her feet to place them on the lift platform of the EZ stand lift, then while the lift was in the upright position the resident slid downward under the sling and fell to the floor hitting the back of her head. The resident sustained a head laceration requiring staples.

The resident's progress note indicated the resident sustained a five-centimeter laceration on her head with staples, her right hand, right arm, and left shoulder had bruising and was tender to the touch following the incident.

A facility nurse educator stated the AP had received training and competency prior to operating the EZ stand mechanical lift, and indicated if the resident was lethargic, not alert enough to hang onto the lift or bear weight, the standing lift should not have been used.

A EZ way customer service representative stated a resident needed to be able to bear some weight and participate in the transfer or the EZ stand lift should not be used. The representative indicated it would be extremely hard and unlikely for a resident to simply slide out of the harness if it was properly attached and the safety belt secured properly around the resident. The representative stated as the resident was raised up to a standing position, staff should make sure the safety belt was pulled tight around the resident's waist to help prevent the resident from falling if they suddenly became weak or let go for some reason. The representative stated causes for a resident to slide out of a harness included staff using the wrong size harness or not buckling/tightening the safety belt correctly.

When interviewed facility nursing staff present at the time of the incident stated the AP did not report concerns of the resident being too tired, lethargic, or weak until after the fall occurred. The staff indicated the resident was known to have spells of lethargy, and indicated if the resident was lethargic the AP should have asked for help but did not. One nurse stated the AP reported the leg safety strap was not used during the transfer, and the resident slipped out.

When interviewed facility leadership stated the resident required one to two staff assistance with transfers using the EZ stand. The leadership staff stated when interviewed the AP reported the resident was lethargic but did not report her concerns to nursing staff until after the

resident fell. The AP's recollection of the steps to complete the transfer safely using the EZ stand mechanical lift were vague, and the AP reported having "no time to react" to prevent the fall which raised suspicion the AP had not attached the harness safety belt around the resident's waist or did not tighten the belt securely. The leadership staff stated she did not know how the resident could have slipped out of the harness unless the harness belt was not on securely. Leadership staff stated the AP did not follow the resident's plan of care to increase the level of assistance during times of weakness and indicated two staff or a full body lift should have been used to transfer the resident safely if she was lethargic.

When interviewed the AP stated the resident was less responsive than normal, and indicated she had to physically place the resident's feet on the lift platform but did not think to report her concerns to the nurse. The AP verbalized the steps used to complete the EZ stand transfer the day of the incident and indicated she did not recall if the resident was able to hang onto the grab bars of the lift and did not recall if she had tightened the harness safety belt securely around the resident's waist or not.

When interviewed the resident's family member stated staff should have used two assist the day the resident fell from the EZ stand lift. The family member indicated aside from the incident they were happy with the care provided by the facility.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: No, not interviewable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP immediately reported the incident to nursing staff. Nursing staff provided first aide and transferred the resident to the emergency department for evaluation and treatment of her

injuries. The facility reported the incident to the common entry point Minnesota Adult Abuse Reporting Center MAARC timely and investigated the incident. The facility reeducated the AP and facility staff on implementing the resident's plan of care and proper use of the EZ stand mechanical lift to ensure competency.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Wabasha County Attorney
Lake City Attorney
Lake City Police Department
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: _____ B. WING _____	C 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52185825M, #H52185824M, and #H52185823M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 The following correction order is issued for #H52185825M, #H52185824M, and #H52185823M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as	21850		

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21850	Continued From page 2 authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure 2 of 2 resident's (R1, and R2) reviewed were free from maltreatment. R1, and R2 were neglected. Findings include: On October 24, 2023, the Minnesota Department of Health (MDH) issued a determination that negelct occurred, and that a individual staff persons were 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.	21850		