Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304201100M
Compliance #: HL304201260C

Date Concluded: April 14, 2025

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Bethany
1953 7th Street South
Brainerd, MN 56401
Crow Wing County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

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 facility neglected a resident when the resident fell, pressed his call light, and was not found by staff for eight hours. The resident's call light was not operational at the time of the incident. The resident was diagnosed with a hip fracture and transferred to a transitional care unit.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident's call light failed to send a signal to staff, the error was an isolated incident, and the facility took appropriate measures to resolve the call light functionality issue. The resident sustained a hip fracture and was receiving therapy in a skilled nursing facility at the time of the investigation.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, and staff schedules. Also,

the investigator observed the resident's room and location where he fell, along with his call pendant.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis. The resident's service plan included assistance with dressing, grooming, and bathing. The resident's assessment indicated the resident was independent in his apartment and had a history of falls.

The facility installed a new call light system two months prior to the incident.

The resident's record indicated staff found the resident on the floor around 6:51 a.m., and the resident reported he had been on the floor since around 10 p.m. the night before. 911 was called and the resident was sent to the emergency room and diagnosed with a hip fracture.

The facility's internal investigation indicated the call light system recorded a signal from the resident's pendant at 11:07 p.m. and while the computer received the signal, it did not get sent out to the staff's walkie talkies.

During an interview, facility management stated after installing the new call light system, there were some issues with signals not being sent to staff and they worked through that with the manufacturer and completed periodic audits to ensure it was working properly. Facility management stated the call lights worked appropriately after troubleshooting and for several weeks there were no issues with its functionality. Facility management stated they do not have a high call light volume, sometimes just five per week, so it would not be unusual for a night to not have any call lights activated. Facility management stated the resident did not have any safety checks on his service plan overnight so staff would not have been in the resident's room overnight.

During an interview, the resident stated he fell in his kitchen and pressed his call light, but no one came. The resident stated he pressed his pendant about every half hour for several hours and he later was told the call light signal never got sent to staff.

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: Not Applicable

Action taken by facility:
The facility reported the incident to MAARC. The facility worked with related vendors to address issues with the call light system and made changes to how call signals are sent to staff.

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
	30420	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	1953 7TH STREET SOUTH BRAINERD, MN 56401

(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 On March 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304201100M/ #HL304201260C. No correction orders are issued.	0 000		