Filed in Fourth Judicial District Court
7/3/2018 10:57 AM
Hennepin County, MN

WRONGFUL DEATH

STATE OF MINNESOTA — DISTRICT COURT

COUNTY OF HENNEPIN — FOURTH JUDICIAL DISTRICT

Barbara Pivec, Trustee for the Next of Kin of Evelyn Schweim, Deceased,

Plaintiff,

vs. **COMPLAINT**

All Temporaries Midwest, Inc. and Francisco Javier Ramirez,

Defendants.

Plaintiff, for her Complaint against Defendants above-named, states and alleges as follows:

I. THE PARTIES

PLAINTIFF

1. **EVELYN SCHWEIM** was a resident of Minnesota at all relevant times, including at the time of her death on September 17, 2017. Ms. Schweim resided in a nursing home in Redwood Falls, Minnesota, known as "Good Samaritan Society-Redwood Falls," at all relevant times, including September 10, 2017.

2. **BARBARA PIVEC**, a resident of Chaska, Minnesota, has been duly appointed as trustee for the next-of-kin of her aunt, Evelyn Schweim.

3. Barbara Pivec brings this action on behalf of the next-of-kin of Ms. Schweim, pursuant to Minn. Stat. § 573.02.

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DEFENDANTS

4. **ALL TEMPORARIES MIDWEST, INC**. is a for profit corporation organized under the laws of Minnesota.

5. All Temporaries Midwest, Inc.'s office address registered with the Minnesota Secretary of State is 3634 Central Avenue NE, Minneapolis, Minnesota (Hennepin County).

6. All Temporaries Midwest, Inc. was registered with the Minnesota Department of Health to operate as supplemental nursing services agency, which allowed All Temporaries Midwest, Inc. to provide temporary employment for nursing assistants in nursing homes at all relevant times.

7. All Temporaries Midwest, Inc.'s office address registered with the Minnesota Department of Health is 3638 Central Avenue NE, Minneapolis, Minnesota (Hennepin County).

8. All Temporaries Midwest, Inc. contracted with The Evangelical Lutheran Good Samaritan Society to provide supplemental staffing at the Good Samaritan Society-Redwood Falls nursing home (herein "the nursing home"), including at the time of Evelyn Schweim's residency at the nursing home.

9. Under the terms of the contract, All Temporaries Midwest, Inc. agreed, *inter alia*:

a. to provide temporary workers for the nursing home, including 30 percent of the nursing home's staffing during the night, on weekends, and on holidays;

b. that the temporary workers provided by All Temporaries Midwest, Inc. would be under the direct control and supervision of All Temporaries Midwest, Inc. at all times even while on the premises and performing work for the benefit of the nursing home;

c. to provide on-site supervision of the temporary workers provided to the nursing home at All Temporaries Midwest, Inc.'s expense;

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d. to perform criminal background studies annually on all temporary workers who would be providing direct care for residents of the nursing home;

e. to use due diligence in the selection and placement of temporary workers at the nursing home;

f. to provide orientation for the temporary workers provided to the nursing home; and

g. to defend, indemnify and hold the nursing home harmless from and against any and all liabilities, claims, damages, and expenses (including attorney's fees and disbursements) that the nursing home would incur as a result of injury resulting from the acts or failure to act by All Temporaries Midwest, Inc. and/or its temporary workers provided to the nursing home.

10. **FRANCISCO JAVIER RAMIREZ** resided in Minnesota at all relevant times, including on September 10, 2017.

11. Defendant Ramirez was an employee of All Temporaries Midwest, Inc., at all relevant times, including on September 10, 2017.

12. All Temporaries Midwest, Inc. is legally obligated to defend and indemnify Francisco Javier Ramirez for civil damages, penalties, or fines claimed or levied against him in this action, pursuant to Minn. Stat. § 181.970, subd. 1.

II. STATEMENT OF FACTS

13. Evelyn Schweim was diagnosed with dementia and arthritis and was severely cognitively impaired. Due to her mental and physical limitations, she required the assistance of two staff members to transfer her safely into and out of the bath tub.

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14. Allied Temporaries Midwest, Inc. provided its employee, Defendant Ramirez, to perform nursing assistant services at the nursing home on September 10, 2017.

15. Defendant Ramirez agreed to and accepted the assignment to perform nursing assistant services at the nursing home on September 10, 2017, including the task of bathing Ms. Schweim.

16. On September 10, 2017, Defendant Ramirez performed the task of bathing Ms. Schweim in a hasty and careless manner. Although he knew that two staff members were required to transfer Ms. Schweim, Ramirez disregarded that requirement and chose not to ask another staff member to assist in transferring Ms. Schweim into the bath tub. He transferred Ms. Schweim from a wheelchair to the tub lift chair by himself.

17. After bathing Ms. Schweim, Defendant Ramirez chose to lift her out of the tub with no other staff assistance, disregarding the requirement that two staff members transfer Ms. Schweim out of the bath tub.

18. Defendant Ramirez chose to lift Ms. Schweim up and over the side of the tub with the tub lift chair raised to its maximum height because he did not want to wait for the water to drain out of the tub. In doing so, Ramirez disregarded instructions for the safe operation of the tub, which direct the care provider to drain the tub completely after the bath, then unlock the tub's door and open it to the widest position to dry the resident. The care provider must then transfer the resident out of the drained tub through the open tub door, using the lift lowered completely to the locked position.

19. While Defendant Ramirez had Ms. Schweim elevated and suspended in the lift chair at its maximum height, Ramirez chose to remove the strap that secured Ms. Schweim in the chair. In doing so, Ramirez disregarded instructions for the safe operation of the tub, which

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directed the care provider not to remove the security strap until after the resident was dried and the lift chair was in its lowest position and locked, to ensure that the resident would not slip out of the lift chair.

20. While he had Ms. Schweim elevated, suspended, and unsecured in the lift chair at its maximum height, Defendant Ramirez chose to attempt to place a sling under his wet and slippery patient, causing her to go forward and fall out of the lift chair.

21. Completely unable to protect herself, Ms. Schweim landed on the hard floor several feet below. She landed on her feet and fell onto her left side, her left ankle twisted, and her left leg had visible broken bones.

22. Although Defendant Ramirez knew that Ms. Schweim was severely injured, he dragged her away from the door by pulling on her gown. Instead of using the phone, walkie-talkie, or call light available in the tub room to call for help, Ramirez left Ms. Schweim alone lying on the tub room floor.

23. The bones of Ms. Schweim's left leg were visible, and only her skin held her left foot to her leg. When ambulance personnel arrived, they determined that emergency air transportation to a level one trauma hospital was necessary due to the obvious severity of her injuries.

24. The ambulance transported Ms. Schweim to the local hospital, where she was diagnosed with comminuted bilateral tibial and fibula fractures and an open fracture of the left ankle. A helicopter transferred Ms. Schweim to a level one trauma hospital in the Twin Cities.

25. The physicians determined that Evelyn Schweim was not a good candidate for the surgical interventions and procedures necessary to treat the extensive orthopedic injuries. With

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no other viable options, Ms. Schweim was placed on comfort cares and received hospice services.

26. Ms. Schweim died on September 17, 2017, due to complications of the multiple skeletal fractures caused by the September 10, 2017 fall from the elevated lift seat.

27. The Minnesota Department of Health ("MDH") investigated the September 10, 2017 injury and determined that Defendant Ramirez neglected Evelyn Schweim. During its investigation, the MDH determined that Ramirez failed to follow policies and procedures by transferring Ms. Schweim without staff assistance, failed to follow the bathing and mechanical lift procedures, and failed to implement safe resident handling and safety rules. The MDH investigation report is attached to and incorporated in this Complaint as Exhibit 1.

III. CAUSES OF ACTION

COUNT ONE
ORDINARY NEGLIGENCE

28. Plaintiff incorporates all consistent paragraphs of this Complaint as if fully set forth under this count and further alleges the following:

29. Evelyn Schweim was a vulnerable adult with physical and cognitive limitations and deprived of normal opportunities of self-protection.

30. Ms. Schweim's safety was entrusted to Defendant Ramirez, who accepted that entrustment.

31. Ms. Schweim was dependent on Defendant Ramirez to provide for her safety at the time she was injured on September 10, 2017.

32. Defendant Ramirez held considerable power over Evelyn Schweim's welfare at the time she was injured on September 10, 2017.

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33. Defendant Ramirez owed a duty to Ms. Schweim to comply with, *inter alia*, the care plan, training, and policies and procedures that directed the care services to be provided for Ms. Schweim on September 10, 2017.

34. Despite the clear direction of the care plan, training, and policies and procedures, Defendant Ramirez attempted to transfer Ms. Schweim from the bath tub without the assistance of a second staff member and without following the proper safety procedures. Ramirez's failure to follow the clear directions for transferring Ms. Schweim safely breached the duty owed to her and constitutes ordinary negligence. The evaluation of whether Defendant Ramirez used reasonable care is not a question involving complex scientific or technological issues and is within the general knowledge and experience of lay persons.

35. As a direct result of the ordinary negligence of Defendant Ramirez, Ms. Schweim suffered traumatic injuries that caused her premature and wrongful death.

36. The wrongful acts and omissions of Defendant Ramirez described above were related to the duties for which his employer, Allied Temporaries Midwest, Inc., had assigned him and were committed within the course and scope of his employment for Allied Temporaries Midwest, Inc.

37. The injury to Evelyn Schweim caused by Defenant Ramirez occurred within work-related limits of time and place created by Defendant Ramirez's employment with Allied Temporaries Midwest, Inc.

38. Neglect of nursing home residents by care providers assigned to take care of them is a well-known hazard in the field and is a foreseeable risk for supplemental staffing agencies, like Allied Temporaries Midwest, Inc.

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39. The ordinary negligence of Defendant Ramirez, acting within the scope of his employment for Allied Temporaries Midwest, Inc. is the negligence of his employer, Defendant Allied Temporaries Midwest, Inc., which is vicariously liable for the negligence of its employee, which caused the wrongful death of Ms. Schweim.

COUNT TWO
NEGLIGENT SUPERVISION AND MANAGEMENT
(Allied Temporaries Midwest, Inc.'s Direct Liability)

40. Plaintiff incorporates all consistent paragraphs of this Complaint as if fully set forth under this count and further alleges the following:

41. As a supplemental nursing services agency, Allied Temporaries Midwest, Inc. owed a direct duty to Evelyn Schweim to use reasonable care in: 1) selecting and placing Defendant Ramirez as a temporary worker at the nursing home on Sunday, September 10, 2017, and 2) providing the direct control and supervision of Ramirez at all times even while he was working at the nursing home, to ensure that he provided direct care services in a safe and careful manner.

42. Allied Temporaries Midwest, Inc. undertook for consideration to render services for the nursing home's residents, including Evelyn Schweim, which it recognized or should have recognized were necessary for her protection against foreseeable risks of harm. Injury to Ms. Schweim was reasonably foreseeable if Allied Temporaries Midwest, Inc. entrusted her care and well-being to staff who lacked the training, experience, competence, motivation, and/or supervision required to meet her needs, including the specific transfer procedures that were required to protect Ms. Schweim against the risk of falling.

43. On September 10, 2017, Allied Temporaries Midwest, Inc. entrusted Ms. Schweim's safety to Defendant Ramirez, a person whom Allied Temporaries Midwest, Inc.

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knew, or should have known with the exercise of reasonable care, was not fit or prepared to safely transfer Ms. Schweim. Allied Temporaries Midwest, Inc. provided Defendant Ramirez to care for Ms. Schweim on September 10, 2017. Ramirez disregarded the fact that he was required to transfer Ms. Schweim with the assistance of a second staff member and to follow specific safety procedures for doing so.

44. Allied Temporaries Midwest, Inc. breached legal duties it owed to Evelyn Schweim to use reasonable care in the management and supervision of its employee, Defendant Ramirez, who was responsible for safely bathing Ms. Schweim on Sunday, September 10, 2017.

45. Allied Temporaries Midwest, Inc. owed these duties of care directly to Ms. Schweim, separate from the duties of Allied Temporaries Midwest, Inc.'s employee, Defendant Ramirez. A finding of vicarious liability by virtue of the relationship between Allied Temporaries Midwest, Inc. and its employees and/or agents, for example the legal theories of recovery alleged in Count One, above, does not preclude a finding of direct liability against Allied Temporaries Midwest, Inc. in this Count because an employer who is found vicariously liable for the acts of its employee may also be found directly liable for harm caused by the employer's own negligence.

46. As a direct and proximate result of Allied Temporaries Midwest, Inc.'s negligent supervision and management, Allied Temporaries Midwest, Inc. is directly liable for its own acts and omissions associated with the placement of Defendant Ramirez as a nursing assistant at the nursing home, which caused the injury to and wrongful death of Ms. Schweim.

IV. DAMAGES

47. Plaintiff incorporates all consistent paragraphs of this Complaint as if fully set forth herein and further alleges the following:

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48. As a direct and proximate result of Defendants' negligence, the next-of-kin of Evelyn Schweim have incurred medical and funeral expenses, and they have sustained pecuniary and non-pecuniary losses within the meaning of Minn. Stat. § 573.02 and were otherwise damaged.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment against Defendants for a reasonable sum in excess of Fifty Thousand Dollars ($50,000.00), together with interest, costs and disbursements herein, and granting such other equitable relief as the Court deems just and equitable.

The undersigned hereby acknowledges that the provisions of Minn. Stat. § 549.211 apply to this case.

KOSIERADZKI SMITH LAW FIRM, LLC

Dated: June 7, 2018

s/ Joel E. Smith

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DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Good Samaritan Society Redwood Falls	H5237010 and H5237011	September 25, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
200 Dekalb Street South	5:00 p.m. to 9:30 p.m.	December 29, 2017
Facility City:	**Investigator's Name and Title:**	
Redwood Falls	Pam Hovdet, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56283	Redwood

☒ **Nursing Home**

Allegation(s)

It is alleged that a resident was neglected when the alleged perpetrator (AP) transferred the resident in a lift and the resident fell resulting in multiple fractures.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion

Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) transfered the resident out of the bathtub in a tub lift chair The resident fell out of the tub chair and sustained multiple fractures. The resident died one week later due to complications from the fractures.

The resident was diagnosed with dementia and arthritis, and was severely cognitively impaired. The resident required two staff assistance when transferring in and out of the tub, and one staff assistance with bathing. The resident required two staff with a total lift and high back sling for transfers due to dementia and arthritis.

The AP transfered the resident from the wheelchair to the tub lift chair with a total lift by him/herself. The AP gave the resident a bath, and proceeded to lift the resident out of the tub in the tub lift chair with no other staff assistance. The AP raised the tub lift chair to the maximum height of three and a half feet and lifted the resident up and over the side of the tub, instead of waiting for the water to drain to slide the resident out through the tub door. The resident was not lowered, but remained completely elevated at three and a half feet in the tub lift chair while the AP dried the resident off with a towel. Then the AP removed the seat belt from around the resident, and attempted to place the total lift sling under the

EXHIBIT 1

resident. The resident was wet and slippery making it difficult for the AP to hang onto the resident. As the resident leaned forward in the chair, the AP lost his/her grip on the resident and the resident fell out the tub lift chair. The resident landed on his/her feet and fell onto the resident's left side. The resident's left ankle twisted and his/her left leg had visible broken bones. The AP left the resident alone in the tub room to obtain assistance from other staff, instead of using the phone, walkie talkie, or call light. The nurse responded and immediately and called 911 due to the severity of the injury.

The ambulance run sheet indicated upon their arrival, skin from the left side of the resident's left leg held the resident's foot on the leg. The bones of the left leg were visible. Ambulance staff notified dispatch to contact the helicopter, due to the severity of the injury. The ambulance transported the resident to the local hospital.

Hospital records indicated the resident was diagnosed with comminuted bilateral tibial and fibula fractures. The resident also had an open fracture of the left ankle. The resident was transferred to a higher level of care hospital by helicopter.

The higher level of care hospital records indicated hip fractures were suspected, however the physician indicated the resident was not a good candidate for any surgical interventions or procedures. The resident was placed on comfort cares, and five days later discharged to hospice services. The resident died two days after his/her admission to hospice.

The resident's death certificate indicated the resident died from complications of multiple skeletal fractures due to a fall from a lift raised multiple feet.

When interviewed, the AP stated s/he felt rushed to give the resident his/her scheduled bath, so the AP did not take the time to ask for staff assistance to transfer the resident into and out of the tub. The AP stated s/he did not want to wait for the water to drain out of the tub, so the AP lifted the resident up and over the side of the tub with the tub lift chair raised to the maximum height, and dried the resident off. While elevated, the AP removed the strap from around the resident that was attached to the chair, and attempted to put the lift sling under the resident. The resident tensed up, leaned forward, and fell out of the tub lift chair. The AP moved the resident away from the door by pulling on the resident's gown, and left the resident alone in the tub room to get help. The AP acknowledged s/he knew the resident required two staff to transfer, and chose not to follow the care plan. The AP stated s/he knew the injury was bad and decided to run and get help, instead of using the phone, walkie talkie, or call light available in the tub room.

The safe operation and daily maintenance instructions for the tub indicated after the bath the tub is drained completely, the door is unlocked and opened to the widest position to dry the resident. The resident is moved out of the tub through the tub door on the swivel lift and lowered completely to the locked position. The instructions state to carefully remove the seat belt to ensure the resident does not slip out of the swivel lift chair, which may require the assistance of another staff to control the resident's transfer.

The police report indicated the AP was charged with a felony of crimes against a Vulnerable Adult. The charge was forwarded to the county attorney.

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The AP was immediately suspended by the facility pending an investigation, and the nursing pool agency informed of the incident. The facility terminated their contract with the nursing pool agency.

The facility contacted the tub manufacturer, and modifications were made to reduce the height limit of the tub lift chair. The manufacturer provided education on proper tub use to staff, and the facility re-educated staff on all the facility's mechanical lifts.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had policies and procedures in place related to abuse and neglect, fall prevention and management, bathing, and the care plan. The AP was trained by the pool agency on federal, state, and local laws, rules and regulations. The facility orientated and reviewed with the AP resident care plans, safety rules, use of mechanical lifts, transfers and the safe resident handling program. The AP failed to follow policies and procedures by transferring the resident without other staff assistance, failed to follow the bathing and mechanical lift procedures, and failed to implement safe resident handling and safety rules. The agency completed a background check on the AP, and provided the facility with this information.

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.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

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State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☐ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(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:

(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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Weight Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Physician Progress Notes
- ☒ Care Plan Records
- ☒ Social Service Notes
- ☒ Skin Assessments
- ☒ Facility Incident Reports
- ☒ Laboratory and X-ray Reports
- ☒ ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- ☒ Hospital Records ☒ Ambulance/Paramedics ☒ Medical Examiner Records
- ☒ Death Certificate ☒ Police Report

Additional facility records:

- ☒ Resident/Family Council Minutes
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Personnel Records/Background Check, etc.
- ☒ Facility In-service Records

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☒ Facility Policies and Procedures

☒ Other, specify: Supplemental Staffing Service Agreement.

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Nine

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings:

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Ten

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify:

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

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☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Facility Tour

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A
Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A
Were photographs taken: ◉ Yes ○ No Specify: Photos of the tub and tub room.

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Redwood County Medical Examiners

Redwood Falls Police Department

Redwood County Attorney

Redwood Falls City Attorney