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Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Glenwood Village Care Center
719 Southeast Second Street
Glenwood, MN 56334
Pope County

Report #: H5402009

Date: August 31, 2009

Date of Visit: July 9, 2009

Time of Visit: 9:30 am

By: Marilyn Norling, R.N.
Special Investigator
Veryl Cermak, R.N.
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of abuse in accordance with federal regulations for long term care facilities at 42 CFR Part 483, Subpart B. In conjunction with the federal investigation, an investigation was also conducted in accordance with the Vulnerable Adults Act (VAA), Minnesota Statutes §626.557 and state nursing home licensing rules, Chapter 4658.

The allegation is: Residents #1 and #2 were mentally and physically abused by employee (G), nursing assistant/alleged perpetrator AP. On June 21, 2009, the AP was heard saying inappropriate things to both residents such as "if you hit me I will hit you back", "Hi Lover", "Do you love me?" Later in the evening, while the AP was feeding resident #2, the AP was prompting resident #2 to ask resident #3 to marry her. The resident said she couldn't because she was already married. When she finally got resident #2 to ask resident #3 to marry her, the AP laughed at her. Resident #1 hit the AP on her buttocks and the AP bent over in front of the resident for the resident to hit her again. While the AP was assisting resident #2 in a Hoyer sling, the resident yelled that it hurt. The AP replied we're supposed to do your exercise (nothing is care planned about exercise). The AP went on to state, "Cry, I want to see you cry." The incidents were witnessed by employee (C), NA. The AP has been terminated.

Investigative Findings:

All employees and persons were interviewed in private as desired and given the Tennessee Statement.

During the course of the investigation, the investigators completed the following tasks:

- Medical records were reviewed for residents #1 and #2
- Staff, family, and resident interviews were completed.
- Facility staffing was reviewed
- Observations were completed on July 9, 2009 from 3:15 pm until 4:30 pm. No concerns were identified.
- The facility's Vulnerable Adults and Resident Rights policies were reviewed.

- Personnel files were reviewed for employee (C) and the AP.
- The facility staff training was reviewed.
- The facility internal investigation into the matter being investigated was reviewed

Medical Records:

Review of the medical record for resident #1 established the following:

- Resident #1 is a long term resident of the facility due to history of cerebral vascular accident (CVA), with left-sided hemiparesis (paralysis).
- The review of the care plan established that resident #1 can be verbally aggressive and sharp with staff, especially to the ones she does not like. She is very specific about her cares. The care plan directs staff to tell resident #1 when her behavior is inappropriate, make sure she is safe, and leave the room returning five minutes later.
- Resident #1 is able to verbalize her pain and complains of left shoulder and left knee pain. The physician has ordered Methadone 7.5 mg twice daily and hot packs to her left knee and shoulder.

Review of the medical record for resident #2 established the following:

- Resident #2 has a diagnosis of Dementia with behavioral disturbance. The resident has confusion with short term memory loss, chronic anxiety and a history of belligerence.
- The care plan for resident #2 states that she is dependent upon staff for all activities of daily living. The care plan directs staff to assist resident #2 to be comfortable in her environment by respecting her wishes, using praise, being patient with the resident, and to not confront or argue with the resident.
- Resident #2 has potential for pain related to progressive degenerative joint disease and spontaneous dislocation of her right knee with failure of total joint replacement. Range of motion to right knee three times a day was discontinued on June 19, 2009. The care plan states that resident #2 is capable of verbalizing her pain.

Interviews:

Employee (C) was interviewed on July 9, 2009 at 1:55pm and stated:

- She worked the evening shift on June 21, 2009. She arrived at the facility between 4:00 and 5:00 pm and the AP told her that they would be partners for the shift.
- While they were providing cares for resident #1, the resident struck the AP and the AP stated, "If you hit me, I'll hit you back." The AP then looked at employee (C) and said, "I wouldn't really hit her, but believe me, I want to. I just want to smash her." Employee (C) verified that the statement was made in full presence of resident #1, who did not respond verbally.
- Resident #2 reached out and struck the AP on her buttocks. The AP stated, "If you are going to do that, I'll bend over." The AP then bent over on the right side of resident #1, stood up and laughed.
- During the evening meal, employee (C) and the AP were both assisting residents in the dining room. The AP told resident #2 to ask resident #3 (a female resident) to marry her. Resident #2 stated she couldn't marry resident #3 because she was married. The AP continued to tell her to ask resident #3 to marry her until resident #2 finally did. The AP laughed as if this was funny. Employee (C) stated that resident #2 appeared upset.
- Later in the evening, employee (C) was visiting with resident # 2 when the AP joined them. The AP began lifting resident #2's left leg and the resident cried out that it hurt. The AP told resident

#2 that we have to do your exercises and continued to move her leg. The AP stated, "Cry, I want to see you cry." Resident #2 stated that she did not want to cry. At that time, the AP talked about resident #2's deceased husband until resident #2 began to cry. The AP then appeared satisfied and the incident ended.

- When putting resident #2 to bed, the resident complained that the washcloth was cold and that she was cold. The AP called her a "brat" on at least three occasions and did not provide any assistance to warm up the resident.
- Employee (C) stated that if pulling on resident #2's leg when it hurt was physical abuse, employee (C) witnessed physical abuse. When asked if she had witnessed emotional abuse, employee (C) stated, "Yes." Employee (C) stated that asking resident #2 to cry and talking about her deceased husband until she did cry was emotional abuse. Employee (C) stated that the AP had humiliated resident #2 in front of other residents at the table when the AP insisted that resident #2 ask resident #3 to marry her. Employee (C) also stated that she believed she witnessed emotional abuse when the AP's remarks and actions made resident #1 feel threatened as evidenced by resident #1 striking out at the AP.
- Employee (C) said that she reported what had happened to employee (D) the next morning.

Employee (D) was interviewed on July 9, 2009 at 11:45 am, and gave the following information:

- She came to work on the morning of June 22, 2009, and employee (C) told her she needed to talk to her. It was between 10:30 and 11:00 am when she met with employee (C). Employee (C) described the events with residents #1 and #2 on the previous evening shift involving the AP.
- Employee (D) immediately took employee (C) and they reported the information to employee (A) who then initiated an internal investigation.
- Employee (D) stated that she was very surprised by the allegations because in her experience, the AP was very caring and attentive to the residents.
- Employee (D) stated that she believed employee (C) was credible when she reported the events of June 21, 2009.

Employee (F) was interviewed on July 9, 2009, at 3:05 p.m., and stated:

- She was present in the dining room on an evening shift on an unknown date. The AP stated to her, that resident #1 was, "beating the shit out of me." The AP told employee (F) that she was going to hit her back and told resident #1, "If you hit me, you are going to go to jail, and do you know what happens to people in jail, they get raped."
- Employee (F) said you didn't really say that did you? The AP told her, "Yes, I did."

Employee (E) was interviewed on July 9, 2009 at 2:35 p.m., and said:

- Employee (E) worked regularly with the AP. She described her as not being very pleasant and basically rude. She stated that how the AP treated the residents, depended on the (AP's) mood.
- Resident #1 and the AP particularly didn't get along well. Resident #1 would hit the AP and the AP would threaten to hit her back.
- Resident #2 would call for her husband, who is deceased, and the AP would tell resident #2 that she could see her husband. This caused resident #2 to call out more and more.
- Employee (E) stated that when things got bad between a resident and the AP, she would tell the AP to get out of the room.
- Employee (E) stated that she did not report what she had witnessed because the AP would threaten her if she told the AP she was going to report her behaviors. During the interview employee (E) stated that she wished she would have reported the AP.

Employee (H) was interviewed on August 4, 2009 at 3:30 p.m., and stated:

- She completed the internal investigation on June 22, 2009, after the events of June 21, 2009 had been reported. The AP was not scheduled to work on June 22, 2009, and was terminated on June 23, 2009.
- She believes that the AP's behavior was a pattern of verbal inappropriate comments directed toward residents.
- Employee (H) stated that usually when she had to speak to the AP regarding her behavior, the AP went on and on, but when she went over the allegations regarding June 21, 2009, the AP was quiet and did not say anything.

The AP was interviewed on August 11, 2009 at 1:25 p.m., and stated:

- The AP denied all of the allegations as they were presented to her. The AP stated that resident #1 had never liked the AP and that she was always rude to her. The AP stated that she was always nice to resident #1 and told resident #1 that she could not hit her back when resident #1 struck her.
- The AP stated that she had never said that she would like to hit resident #1, and that she never bent over in front of resident #1 so that resident #1 could strike her buttocks.
- The AP stated that it was a different staff member who told resident #1 that she could be sent to jail and raped for striking out at staff.
- The AP stated that she did not tell resident #2 to ask resident #3 to marry her. The AP stated that she told resident #2 to ask resident #3 to be her friend.
- When questioned regarding the lifting of resident #2's leg, the AP stated that the AP told her that her leg hurt so she lifted her leg, and that she told resident #2 that she should go to physical therapy to get help for her leg if it hurt. The AP stated that she told resident #2 not to cry and that it was employee (C) who told resident #2 to cry. The AP stated that she asked resident #2 if she was married and resident #2 told her that her husband had died, so the AP asked how he died. Resident #2 told the AP, and the AP stated that she told her that was too bad.
- The AP stated that she did not get along with her co-workers and that the other staff at the facility "ganged up" on her. The AP stated that she had reported the problems she was having to the nurses but nothing changed.
- The AP stated that when she was terminated she explained what had happened to employee (H) but it did not make any difference.
- The AP stated that she is frustrated and that it "hurts" because she never did anything wrong. The AP stated that she had never physically or emotionally abused any resident at any time.

Resident #1 was visited at 4:00 p.m. on July 9, 2009. When questioned regarding staff, she stated staff is good to her and she likes living here. Resident #1 also stated, "She bites me." When questioned further, resident #1 was unable to provide any further details regarding this statement.

Resident #2 was visited at 4:10 p.m. on July 9, 2009. She was unable to participate in any meaningful conversation with the investigator.

Visits with additional residents and family members did not identify any resident or family concerns.

Personnel Files:

Personnel files were reviewed for employee (C) and the AP on July 9, 2009.

- Employee (C) has been employed at the facility since April 20, 2009. She completed Vulnerable Adults training on May 25, 2009, and Residents' Rights training on June 19, 2009.
- The AP had been employed at the facility since January 30, 2009, and had completed Vulnerable Adults training on May 23, 2009, and Residents' Rights training on February 23, 2009 and March 17, 2009. The AP also completed a course titled, Preventing, Recognizing, and Reporting Resident Abuse, on March 18, 2009.
- The (AP's) Employee Performance Evaluation, dated April 30, 2009, did not identify any issues related to patient care.

Internal Investigation:

The findings of the internal investigation were consistent with the findings of the investigation.

Conclusion:

As defined by federal regulatory requirements at 42 CFR 483.13(b), and the current statutory definition specified within Minnesota Statutes §626.5572, the preponderance of evidence indicates that **physical and emotional abuse did occur** in connection with the allegation that on June 21, 2009, the AP physically abused resident #2 when she lifted her leg after the resident had told her that she was hurting her. In addition, the AP emotionally abused resident #2 when she intentionally talked about resident #2's deceased husband in an effort to make the resident cry, and when she badgered resident #2 into asking resident #3 to marry her. Resident #2 was visibly upset after this incident.

The AP emotionally abused resident #1 by taunting her with threats to strike her, send her to jail, and the threat of being raped. Resident #1 would respond by becoming upset and striking the AP.

The "mitigating factors" in Minnesota Statutes, §626.557, subdivision 9c (c) were considered and it was determined that the AP is responsible for the abuse. The AP will be notified of the right to request reconsideration and/or appeal the maltreatment finding.

Since the allegation of abuse by an identified employee is substantiated, 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 in State law. The employee will be notified of the right to request reconsideration and a hearing to challenge these findings.

At the time of the investigation, the facility had taken corrective action related to this incident. Staff had received further training regarding resident rights and the necessity to report immediately if they witness any form of abuse or neglect. Therefore, no Federal deficiencies or State licensing orders are issued.

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Glenwood City Police Department
Pope County Attorney
Glenwood City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2009
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NAME OF PROVIDER OR SUPPLIER GLENWOOD VILLAGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 719 SOUTHEAST 2ND STREET GLENWOOD, MN 56334
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(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) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey was conducted to investigate complaint H5402009. No deficiencies are issued.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.