

SF/JR



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Robbinsdale Rehab & Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422
Hennepin County

Report #: H5417145

Date: 7/2/2009

Date of Visit: 2/18/2009 & 2/19/2009
Time of Visit: 2:00 p.m. & 11:00 a.m.

By: Pat FitzGibbon, R.N.
Special Investigator

Lori Wear, R.N.
Special Investigator

Nature of Visit:

An unannounced visit was made in order to investigate the following allegation of physical 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.

Warning: This report contains graphic language, which may be offensive to readers. The purpose for the use of this language is to demonstrate the severity of the abuse detailed in the report and to accurately document the abuse for possible legal proceedings.

The allegation is: Resident #1 was physically abused when, during the morning of January 25, 2009, employee (E)/nursing assistant (NA)/alleged perpetrator (AP) threw a four ounce glass of water into her face. In addition, the AP put her finger on resident #1's forehead and stated "that will teach you not to fuck with me...I bet you won't throw water at me again," (referring to an incident from earlier on that same date when resident #1 threw water into the AP's face when the AP blocked resident #1's access to an office area). Two staff observed this incident and the AP reported the incident to a nurse. The nurse did not immediately report the incident to administration in accordance with the facility policies. The AP and the nurse were suspended and later terminated.

Investigative Findings:

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

The investigation included a review of resident #1's medical record and the medical records of nine additional residents; incident/accident logs for January and February 2009; policies and procedures

regarding the Vulnerable Adults Act and personnel files for five staff. Additionally, eight residents were interviewed with no concerns noted.

Medical Record:

A review of resident #1's medical record revealed diagnoses including cerebrovascular accident (CVA), developmental delay, mild mental retardation with learning disability and dementia. A Resident Transfer form dated 2/5/2009 documents that she is forgetful, has impaired judgment, is restless and wanders.

Internal Investigation:

The facility's internal investigation included interviews with staff witnesses, a review of personnel files and resident #1's medical record. The AP and the licensed nurse were both suspended during the course of the investigation. Resident #1 was examined and was found to have no injuries. Her behavior is unchanged after the incident. The investigation revealed that employee's (F) and (G) witnessed the AP throw water in the face of resident #1; poke her in the forehead and state "I bet you'll never throw water in my fucking face again." Employee (D)/licensed practical nurse (LPN) was interviewed she expressed an awareness of the incident and confirmed that she had not reported it. As a result of the facility investigation, the AP and employee (D) were terminated from the facility.

Interviews:

Employee (F)/nursing assistant (NA) was interviewed on 3/25/2009 at 10:03 a.m. and stated the following regarding the events which occurred during the night shift of 1/25/2009:

- The AP was working on the 2nd floor and came up to the 3rd floor on her break. She witnessed the AP try to stop resident #1 from going down the north side hallway. Resident #1 had a cup of water in her hand and threw it in the face of the AP. Employee (G) "broke it up" and redirected resident #1 because she had a tendency to become violent.
- She witnessed the AP come "flying" around the corner, throw water in resident #1's face and poke her in the forehead twice. Resident #1 wiped her eyes, had her head down and didn't say anything. She stated resident #1 seemed to be in "shock."
- She reported this incident to employee (D), LPN.

Employee (G), NA was interviewed on 3/26/2009 at 9:25 a.m. and stated the following regarding the events which occurred during the night shift of 1/25/2009:

- Resident #1 came out of her room between 2:30 – 3:00 a.m. as she normally does. She stated that resident #1 is usually hungry or thirsty at that time. The AP was on the 3rd floor having coffee.
- She witnessed the AP try to block resident #1 from going down a hallway. She saw resident #1 throw a medication cup of water into the AP's face. Employee (G) redirected resident #1 away from the AP and tried to get her calmed down.
- She then witnessed the AP come up and throw water in resident #1's face. She stated that she and employee (F) looked at each other in "amazement." She stated that the AP also put a hand on the resident's forehead and stated you won't throw water on anyone again.
- She stated that resident #1 was trying to get the water out of her face and that she thought it was irritating her eyes.
- She reported this event to employee (D), LPN.

Attempts to reach employee (D), LPN and employee (E), NA/AP were unsuccessful.

Policies and Procedures:

A review of the facility's Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property procedure dated January 2007 documents that staff is to "notify the shift supervisor immediately if abuse.....occurs." It also directs staff to "report the incident immediately to the Administrator."

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 abuse did occur** in connection with the allegation that resident #1 was physically abused when she had water thrown in her face, was poked in the forehead and told "that will teach you not to fuck with me...I bet you won't throw water at me again." Interviews and documentation review established the following:

- Resident #1 had a pattern of wandering and was often up at night. She typically would look for something to eat or drink. She could be resistive to redirection.
- Employee's (F) and (G) witnessed employee (E), AP throw water in the face of resident #1, poke her in the forehead and state that she (resident #1) would not be throwing water in the AP's face again.
- Employee's (F) and (G) reported the incident to employee (D). Employee (D) did not make an internal report per the facility's protocol.
- Employee's (D) and (E) did not respond to attempts to reach them for interview.

The "mitigating factors" in Minnesota Statutes, §626.557, subdivision 9c (c) were considered and it was determined that the perpetrator is responsible for the abuse. The employee 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.

xc: Division of Compliance Monitoring - Licensing & Certification
Robbinsdale City Police Department
Hennepin County Attorney
Robbinsdale 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: 245417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2009
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NAME OF PROVIDER OR SUPPLIER ROBBINSDALE REHAB & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422
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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 H5417145. No deficiencies were issued.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.