DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52361462M
Date Concluded: December 22, 2022
Compliance #: H52361930C

Name, Address, and County of Licensee Investigated:
Benedictine Health Services
935 Kenwood Avenue
Duluth MN 55811
St Louis County

Facility Type: Nursing Home

Evaluator's Name: Carol Moroney RN, Special Investigator

Finding: Not Substantiated

Nature of Visit:
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) abused the resident when the AP called the resident "lazy". When the resident yelled and shook a fist at the AP, the AP shook a fist back at the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the AP was heard saying 'don't be lazy,' shook a fist and made a grunting sound, it did not meet the definition of emotional abuse. The AP indicated he put his hand up in a defensive manor, however; did not shake his fist at the resident and denied calling the resident lazy. The AP also stated to have a medical condition which could resemble a grunting noise.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of care plan, and progress notes.

The resident resided in a skilled nursing facility. The resident's diagnoses included schizoaffective disorder and anxiety disorder. The resident's care plan included the residents need for assistance with grooming, bating, oral cares, walking, transferring, mobility, and bowel/bladder. The resident was impulsive with needs and desires which required immediate attention.

During the facilities investigation, the AP stated he had a medical condition which could resemble a grunting noise after running down the hall. The AP stated he had helped the resident lie down in bed; he told the resident "This is not the time to be lazy". The AP stated he clearly, he did not call the resident lazy. The AP stated he put his hand up in a defensive manor after the resident put his fist up at him. The facility's intervention included re-education of all staff on maltreatment, on what suspected abuse was, and how to report any suspected abuse immediately.

During an interview with the nursing assistant who reported the event, she stated she could not remember the event or any details about it.

The AP declined to be interviewed.

The client was not able to be interviewed.

The family declined an interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No. Not able due to cognition.

Family/Responsible Party interviewed: No. Declined.

Alleged Perpetrator interviewed: The AP declined to be interviewed. The facilities investigation was complete with the APs interview.

Action taken by facility:
The facility suspended the AP during the investigation. The AP and all other staff were re-educated appropriately.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00861	A. BUILDING: ______ B. WING ______	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE** **DULUTH, MN 55811**

(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 H52361462M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

Minnesota Department of Health

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		