Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52402103M
Compliance #: H52403382C

Date Concluded: February 23, 2023

Name, Address, and County of Licensee Investigated:
Lake Winona Manor
865 Mankato Avenue
Winona, Minnesota, 55987
Winona County

Facility Type: Nursing Home

Evaluator's Name: Danyell Eccleston, 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 alleged perpetrator (AP), a facility staff, physically abused a resident when the AP forcefully put her hand on the resident's mouth to stop the resident from screaming.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP was observed placing her hands on the resident's face and head when the resident was yelling. However, the AP's action did not rise to the level of maltreatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of medical records, employee records and policies.

The resident's diagnoses included Alzheimer's disease and impaired mobility. The resident's service plan included assistance with activities of daily living, redirection, comfort, toileting,

social activities, and transferring. The resident's care plan indicated the resident would loudly yell and repositioning the resident, taking her to the bathroom, or offering comfort items could help reduce the behavior.

During an interview a facility leadership staff stated the resident had memory issues and could communicate but was often not aware of where she was. The leadership member stated the resident would call out and escalate to hollering, which often occurred when she needed to use the bathroom or was uncomfortable. The leadership member stated the AP was friendly, interacted well with peers, and preferred to not work on the unit where the resident resided because the unit had residents with greater memory loss and behaviors. The leadership member stated she reviewed video footage without audio from the time in question. In the video the AP turned the resident, who was in a wheelchair, towards her and the AP "tapped" the resident's chin in a motion that appeared to be an attempt to close the resident's mouth. The AP also "tapped" the resident on the head and the resident appeared to swing at the AP. The leadership member stated the video showed the AP use a flat open hand with "more force than a gentle closing" on the resident's chin. The leadership member stated she was not aware of any prior concerning interactions between the resident and the AP.

During an interview, an unlicensed staff member stated on the day in question the resident was in an angry mood and was yelling loudly and screaming. The unlicensed staff member stated she saw the AP "shove" the resident's mouth shut in an effort to stop the resident from screaming which made the resident angrier. The unlicensed personnel stated she did not recollect the words that were said between the AP and the resident and after the incident the resident was given a cup of coffee and a warm blanket which calmed her. The unlicensed staff member stated the resident didn't have any physical injuries. She stated she had worked with the AP in the past and didn't have concerns on how the AP treated residents.

During an interview, a second unlicensed staff member stated she saw the AP put her hand over the resident's mouth to stop the resident from yelling. The AP also tapped the resident on the head and made a comment about the resident's brain not working. The staff member stated the AP did not touch the resident in a hard way that would have left a mark. The staff stated the resident appeared surprised at the time of the incident, however, the resident seemed to not remember the incident and was back to her baseline later that day.

During an interview, the AP stated she did not remember the day in question and believes that her actions could have been interpreted incorrectly.

During an interview, family members of the resident stated they believed the resident received good care at the facility and that they did not have concerns.

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:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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, resident deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal review of the incident.
The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
No further action taken.

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
	00701	A. BUILDING: _____ B. WING _____	C 02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

(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 #H52402103M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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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		