

**Office of Health Facility Complaints Investigative Report**  
**PUBLIC**

<b>Facility Name:</b> Augustana Healthcare Center of Minneapolis			<b>Report Number:</b> H5242102	<b>Date of Visit:</b> April 12, 2016
<b>Facility Address:</b> 1007 East 14th Street			<b>Time of Visit:</b> 8:15 a.m. to 2:30 p.m.	<b>Date Concluded:</b> January 23, 2017
<b>Facility City:</b> Minneapolis			<b>Investigator's Name and Title:</b> Barbara White, RN	
<b>State:</b> Minnesota	<b>ZIP:</b> 55404	<b>County:</b> Hennepin		

**Nursing Home**

**Allegation(s):**

It is alleged that a resident was abused when an alleged perpetrator (AP) physically abused the resident by slapping the resident.

- 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, abuse occurred. Staff witnessed the alleged perpetrator (AP) slap the resident.

The resident had diagnosed dementia with behaviors. The resident had a care plan for staff to provide a consistent calm environment and remove stimulation from the area when the resident was upset.

One morning, the resident was sitting at a table in the dining room and became upset about a spill on the floor. The resident raised his/her voice and demanded the AP clean up the spill. The AP was observed by staff to shake his/her finger to the resident and say "I'm going to lose my job if you hit me today." The resident stood up and raised fists in front of his/her body. Another staff instructed the AP to step away from the resident, and offered to clean up the spill. The AP didn't move, the resident swung his/her arms toward the AP, and the AP slapped the resident once with an open hand to the face. The resident continued to yell at the AP. The staff who had witnessed the AP strike the resident intervened and the AP was removed from the area. Staff assessed the resident, the resident had a red mark on his/her face, but did not require any first aid or medical care. The resident did not have a change in mood after the incident.

When the resident was interviewed, s/he was not able to recall the events of the incident.

The facility terminated the AP's employment. The AP did not respond to requests for an interview.

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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:

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**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 trained the AP on the vulnerable adult law and how to approach residents with dementia. The AP had been given the employee handbook that described appropriate behavior in the work place. The facility conducted background checks, provided supervision, and staff intervened during to altercation to direct the AP to leave. The facility terminated the AP at the time of the incident, and provided additional training to staff.

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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 Met

The facility was found to be in compliance with Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B). No deficiencies were issued.

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State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met

The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

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State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

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State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met

The requirements under State Statutes for Chapters 144 & 144A were not met.

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State licensing orders were issued:     Yes                       No

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

**Compliance Notes:**

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**Facility Corrective Action:**

The facility took the following corrective action(s):

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**Definitions:**

**Minnesota Statutes, section 626.5572, subdivision 2 - Abuse**

"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;

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;

**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

Facility Name: Augustana Healthcare Center of  
Minneapolis

Report Number: H5242102

- Medication Administration Records
- Nurses Notes
- Physician Orders
- Physician Progress Notes
- Care Plan Records
- Facility Incident Reports

**Other pertinent medical records:**

**Additional facility records:**

- Staff Time Sheets, Schedules, etc.
- Facility Internal Investigation Reports
- Personnel Records/Background Check, etc.
- Facility In-service Records
- Facility Policies and Procedures

Number of additional resident(s) reviewed: one

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: \_\_\_\_\_

**Interviews: The following interviews were conducted during the investigation:**

Interview with complainant(s)  Yes  No  N/A

Specify: \_\_\_\_\_

If unable to contact complainant, 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: The resident was not able to recall the event.

Did you interview additional residents?  Yes  No

Total number of resident interviews: Ten

Interview with staff:  Yes  No  N/A Specify: \_\_\_\_\_

**Tennessee Warnings**

Tennessee Warning given as required:  Yes  No

Total number of staff interviews: Five

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:
<u>04/15/2016</u>	<u>2:45 p.m.</u>	<u>05/10/2016</u>	<u>12:00 p.m.</u>	<u>07/06/2016</u>	<u>3:00 p.m.</u>

If unable to contact was subpoena issued:  Yes, date subpoena was issued 05/11/2016  No

Were contacts made with any of the following:

Emergency Personnel  Police Officers  Medical Examiner  Other: Specify \_\_\_\_\_

**Observations were conducted related to:**

- Nursing Services
- Dignity/Privacy Issues
- Safety Issues
- Meals
- 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: \_\_\_\_\_

cc:

**Health Regulation Division - Licensing & Certification**

**The Office of Ombudsman for Long-Term Care**

**Minneapolis Police Department**

**Hennepin County Attorney**

**Minneapolis City Attorney**

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

PRINTED: 12/09/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245242</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1007 EAST 14TH STREET</b> <b>MINNEAPOLIS, MN 55404</b>		
(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	
F 000	INITIAL COMMENTS  An abbreviated standard survey was conducted to investigate case #H5242102. Augustana Health Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000			

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00164</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AUGUSTANA HEALTH CARE CENTER OF MINI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1007 EAST 14TH STREET MINNEAPOLIS, MN 55404</b>
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2 000	<p>Initial Comments</p> <p><b>*****ATTENTION*****</b></p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> A complaint investigation was conducted to investigate complaint #H5242102. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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2 000	Continued From page 1  <a href="http://www.health.state.mn.us/divs/fpc/profinfo/info.html">http://www.health.state.mn.us/divs/fpc/profinfo/info.html</a> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights  Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.  This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R1) reviewed were free from physical abuse.	21850		

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21850	<p>Continued From page 2</p> <p>The findings include:</p> <p>R1's medical record was reviewed. The nurse practitioner progress note dated 3/5/16 indicated R1 had diagnoses including dementia with behaviors.</p> <p>The nursing progress note dated 3/23/16 at 6:08 a.m. indicated R1 became upset about a spill on the floor and was yelling at NA-F. NA-F was talking with the resident, the resident struck NA-F in the arm, then NA-F slapped the resident.</p> <p>The care plan dated 1/29/15 for behaviors indicated staff were to help the resident to calm by providing a consistent quiet approach and to remove from area if agitated.</p> <p>The Director of Health Information was interviewed on 4/12/16 at 10:00 a.m. and stated that she intervened on 3/23/16 at 6:00 a.m. when she heard yelling in the dining room, and observed NA-F slap R1 on the face with an open hand.</p> <p>The Licensed Practical Nurse (LPN)-D was interviewed on 4/12/16 at 11:15 a.m. and stated she was in the dining room on 3/23/16 at 6:00 a.m. and saw NA-F slap R1 on the left side of the face leaving a red mark.</p> <p>The employee handbook policy signed by NA-F on 10/9/15 indicated all verbal, physical, or mental abuse of a resident is not tolerated. The facility vulnerable adult policy also stated no abuse was tolerated. The facility had trained NA-F on 10/11/15 regarding vulnerable adult policy and definitions of abuse.</p> <p>SUGGESTED METHOD OF CORRECTION: The</p>	21850		
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Minnesota Department of Health

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21850	<p>Continued From page 3</p> <p>Director of Nursing or designated person to review policies and procedures, revise as necessary, educate staff on revisions, and monitor to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21850		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 00164	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/17/2017
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NAME OF FACILITY AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 EAST 14TH STREET MINNEAPOLIS, MN 55404
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21850	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # MN St. Statute 144.651 Subd. 14	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	01/03/2017	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/9/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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