Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5251051M **Date Concluded:** June 23, 2022

Name, Address, and County of Licensee Investigated:
Riverview Hospital and Nursing Home
323 South Minnesota Street
Crookston, MN 56716
Polk County

Facility Type: Nursing Home

Evaluator's Name:
Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 roughly handled the resident when the resident was in the recliner. It is also alleged the AP neglected the resident when the AP left the resident on the floor and watched the resident struggle to turn over and get up off the floor for an unknown amount of time.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. Facility video showed the AP assisted the resident to the floor, but then left the resident on the floor struggling to get up for over half an hour. The AP sat near the resident but made no attempt to help the resident up and prevented an unlicensed staff from helping the resident up. The AP had a history of emotional abuse of a vulnerable adult in another state several years ago, as well as in Minnesota within the previous year.

The Minnesota Department of Health did not substantiate abuse. Although it was reported facility video showed the AP push the resident into his recliner three times, the actions of the AP did not meet the definition of abuse and the resident was unharmed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of personnel records, board of nursing records, resident records, and policies and procedures related to maltreatment of vulnerable adults.

The resident lived in a nursing home that specialized in dementia care. The resident's diagnoses included dementia and history of stroke with resulting right-side weakness and inability to produce language. The resident's service plan included assistance with communication. The care plan directed staff to face the resident directly, obtain the resident's attention before speaking, provide a quiet and non-hurried environment, and repeat phrases as needed. The resident's care plan also included assistance with behavioral symptoms of hollering and swearing. The care plan directed staff to intervene as safety allowed, provide diversion and redirection, avoid power struggles, and maintain a calm environment.

The facility report indicated an unlicensed staff entered the facility living room one evening and saw the resident laying on the floor with the AP sitting nearby. The unlicensed staff asked the AP if they should get the resident off the floor and back into the recliner. The AP told the unlicensed staff the resident could stay on the floor since he wanted to get out of the recliner. The AP then left the area.

During an interview, the unlicensed staff stated she saw the resident on the floor and offered to help the AP get the resident up, but the AP said "no". The unlicensed staff stated she asked the AP a few times to assist getting the resident off the floor because she felt it was not right to leave the resident on the floor, but the AP refused and walked away. The unlicensed staff stated she was confused about what to do, because she could not get the resident up by herself and the AP was in charge. The unlicensed staff stated she put a rolled-up blanket under the resident's head for comfort. The unlicensed staff stated the resident rolled from side to side as he tried to get up. The unlicensed staff stated she had to leave the resident to answer a call light and when she returned, another unlicensed staff (#2) had gotten the resident off the floor and back in the recliner.

During an interview, unlicensed staff #2 stated on the night of the incident, she was showering another resident when the AP came into the bathroom. The AP told her that the resident had fallen. Unlicensed staff #2 stated the AP appeared frustrated with the resident's attempts to get up from the recliner. When unlicensed staff #2 came out of the shower 15-20 minutes later, she observed the resident laying on the floor with no staff around. Unlicensed staff #2 stated the resident was rolling from side to side on the floor trying to get up. Unlicensed staff #2 stated she used a gait belt and assisted the resident into the recliner, put up the footrest, and covered him with a blanket.

During an interview, an administrative staff stated she viewed the facility surveillance video of the dining area and saw the AP push the resident down into the recliner several times when he tried to get up. The administrative staff stated she saw on the video, the AP lowered the footrest of the recliner, lifted the resident under the arms and placed the resident on the floor. The administrative staff stated she observed the AP sit 20 feet away from the resident in a chair, while the resident struggled, crawled, and tried to get up. The administrative staff stated the video showed the first unlicensed staff entered the area less than 10 minutes after the AP placed the resident on the floor and tended to the resident by putting a pillow under his head, while the AP walked away. The administrative staff stated the video showed unlicensed staff #2 enter the area about 30 minutes later and lift the resident into the recliner. The administrative staff verified the resident was left on the floor for over 30 minutes.

During an interview, a family member stated the facility notified her of the incident that the AP put the resident on the floor and left him there. The family member stated she felt the facility did a good job overall with the resident.

When interviewed the AP stated she never received appropriate training for dealing with resident behaviors. The AP stated the facility did not include interventions in the resident's care plan for prevention of behaviors, "placing residents in holds", or what to do if "attacked" by a resident. The AP stated on the night of the incident the resident was combative, punching her, and the resident put himself on the floor. The AP stated the resident sat on his butt on the floor. The AP stated since the resident struck her multiple times, she did not feel safe getting him up. The AP stated the resident's care plan indicated he was a fall risk, so should not be alone in a room. However, the AP stated the resident was only alone for two minutes.

Review of the AP personnel file indicated the facility provided the AP with training that included abuse prevention, resident rights, dementia, problem solving anger/aggression, problem solving anxiety, problem solving mood swings, problem solving sleep problems/sundowning, problem solving wandering, dementia behaviors, dementia management, and vulnerable adults.

In conclusion neglect was substantiated and abuse was not substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

"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, unable to communicate
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided education to staff regarding maltreatment of vulnerable adults and reporting maltreatment.
The AP no longer works at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Polk County Attorney
Crookston City Attorney
Crookston Police Department
Minnesota Board of Nursing
North Dakota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 #H5251051M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/07/22

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2 000	Continued From page 1 #H5251051M, tag identification 1850. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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 "reviewed" 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	state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	21850		7/7/22

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21850	Continued From page 2 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 interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On June 23, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	