Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5257016M
Compliance #: H5257015C

Date Concluded: March 1, 2021

Name, Address, and County of Licensee Investigated:
St Otto's Care Center Inc.
920 4th Street SE
Little Falls, MN 56345
Morrison County

Facility Type: Nursing Home

Investigator's Name:
Julie Serbus, 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.

Allegation(s):
It is alleged: The Alleged Perpetrator (AP) when he grabbed and/or twisted the resident's arms during cares.

Investigative Findings and Conclusion:
Abuse was substantiated. There is sufficient evidence to conclude the AP's conduct caused bilateral bruising to the resident's forearms. The AP was responsible for the maltreatment.

The investigation included record review and interviews. The investigator conducted interviews with administrative staff, nursing, and unlicensed personnel. In addition, the investigator interviewed the resident's family member.

The resident's diagnoses included, but were not limited to, stroke, weakness, vascular dementia without behaviors, anxiety, major depressive disorder, and aphasia. The resident's care plan indicated the resident required assistance with bed mobility, transfers, and all activities of daily living. The resident's comprehensive assessment indicated he had cognitive loss and dementia

with short-term memory loss.

Review of the facility's investigation notes indicated the resident was able to verbally communicate his needs. A hearing loss was indicated; the resident does wear hearing aids. The resident required the assistance of one staff member for cares.

Review of facility documentation indicated that on the resident's bruises were observed by staff one evening while receiving a bath. A licensed practical nurse (LPN) completed a skin assessment the registered nurse (RN) on-duty at the time was immediately called into the room to assess the resident's bruises. The resident's right forearm had dark purple bruising covering the top of his right forearm. The same forearm also had a couple of separate bruises as well. The resident's left forearm had a smaller bruise, that had appeared possibly older. When nursing staff asked the resident what happened to cause the bruising, the resident explained the AP (an unlicensed staff member) caused it and pointed to his right arm. The resident went on to explain that the night before while in the bathroom, the AP wanted the resident to take a bath. The client stated the AP took the resident's arm, and then the resident made a twisting motion with his hands with both of his fists together indicating the AP's actions with the resident's right arm.

Review of the initial police report identified the resident had bruising and listed the name of the perpetrator of the bruising as the AP. The supplemental police report with information from the facility Administrator read he did not believe the bruising had been intentional or that a crime occurred.

When interviewed, the LPN stated she was asked to assist the resident in the bathroom the evening prior to the resident's bruising. The LPN said the AP told her the resident had been uncooperative. As the LPN assisted the resident to dress and get into bed, the resident stated the AP had grabbed his arms. The LPN stated, at the time, she observed no bruises to resident's arms; however, the forearm bruising was noted on the resident's skin assessment the next day. The LPN stated she did not report the incident the night of the resident's bath as there were no evident signs of harm. The next evening, she stated she completed a bath skin audit and noted the bruises on the resident's right and left forearms. She stated she immediately reported the bruising to the RN.

When interviewed, the RN stated she was asked to assess the resident's arms due to observed bruising. The RN stated the resident alleged the AP twisted his arm to cause the bruising. The RN stated the passed the information regarding the incident with the resident and AP to a second RN, who is also the facility co-owner, so that she could go and assess the resident.

When interviewed, a RN/facility co-owner stated the resident was able to name the AP and reported that the AP twisted his arm. She stated she then called the Administrator to report the bruising. The RN/co-owner stated they did not realize until later that evening that the resident's bruises were caused from an incident the night before. The RN stated the Administrator is the one who completes the facility's internal investigations. The RN stated the AP was not scheduled

to work the evening the bruises were identified or the following day.

When interviewed, the Administrator stated he was notified the evening the bruises were discovered. He stated the resident alleged the AP grabbed and twisted his arms. The Administrator stated he interviewed the resident that evening, and then interviewed the AP in person three days later. The Administrator said the AP told him the night of the alleged incident, the resident's gown was wet, so the AP was in the process of trying to put a dry gown on resident. The AP told the Administrator the resident was not allowing him to change the gown, so he went out to find another staff person to assist him. The Administrator said the AP claimed he did not go back into room after that leaving to find another staff person. The Administrator stated the AP told him the resident tried to say the bruises were caused by the AP, and, at first, asserted the bruising would not turn purple like that right away. The Administrator stated the AP claimed the resident's forearm bruises were already there (prior to the gown change). The Administrator said, initially, the AP said he did not twist the resident's arm; however, after more discussion, the AP said he did not mean to squeeze the resident's arm and that he was just trying to assist the resident. The Administrator reported the AP stated the resident was not listening, but that he probably should have not raised his voice to him or grabbed his arms.

Attempts to contact the AP for interview were unsuccessful. The AP did not response to a subpoena for interview.

In conclusion, abuse was substantiated against the AP.

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.

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;
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.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes, but very limited due to the resident's cognitive status and hearing loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. The AP answered when the investigator called the first time but declined an interview at that time as he stated he needed to check schedule. The AP did not respond to additional calls or to subpoena for an interview.

Action taken by facility:
The facility conducted an internal investigation and reported the AP to the Nursing Assistant Registry. 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. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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 Minnesota Nursing Assistant Registry
Morrison County Attorney's Office
Little Falls, Minnesota City Attorney
Little Falls Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00817	A. BUILDING: _____ B. WING _____	C 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(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 #H5257016M, 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 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/02/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00817	A. BUILDING: _____ B. WING _____	C 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(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	Continued From page 1 #H5257016M, 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	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.	
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.	21850		4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00817	A. BUILDING: _____ B. WING _____	C 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(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
21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one resident reviewed (R1) was free from maltreatment. R1 was physically abused. Findings include: On March 1, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that the 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	Reviewed 4/2/2021 once provided by MDH nearly 7 months after original investigation was completed.	