*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** H5262038M **Date Concluded:** February, 3, 2020

**Name, Address, and County of Licensee Investigated:**
West Wind Village
1001 Scotts Avenue
Morris, MN 56267
Stevens County

**Facility Type: Nursing Home** **Investigator's Name:** Jill Hagen, RN, PHN, 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) physically abused Resident #1, Resident #2, and Resident #3. The AP held a pillow over Resident #1's face and hit Resident #2 and Resident #3. The AP said he intentionally left no evidence of harming the residents.

**Investigative Findings and Conclusion:**
Abuse was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP held a pillow over Resident #1's face. The AP was also rough with cares and threw Resident #2 into his wheelchair to intentionally hurt him. Additionally, the AP slapped Resident #3 across the face and shoved her against her bed.

The investigation included interviews with the facility administrative staff. In addition, the investigator contacted law enforcement. The investigation included review of Resident #1, Resident #2 and Resident #3's medical record, facility policies and procedures, and the facility investigation.

Resident #1's diagnoses included dementia, chronic low back pain and agitation. Resident #1 was hard of hearing. Resident #1 resided in the facilities secured memory care unit. Resident #1 was able to make some of her needs known to staff but required staff to anticipate her needs especially when she was agitated. During times of agitation, the care plan directed staff to offer a snack and other diversion techniques such as conversations with Resident #1's about her previous occupation. Resident #1 required staff assistance and a walker to ambulate and staff assistance to complete all activities of daily living. Resident #1 was not capable of reporting abuse.

Resident #2's diagnoses included Parkinson's disease and dementia. Resident #2 was hard of hearing with poor eyesight. Resident #2 was capable of making his needs known to staff but also required staff to anticipate his needs. The care plan directed staff to speak to Resident #2 at his eye level, write messages with a note book, or use a pocket talker (a device that amplified voices). Resident #2 used a wheelchair for his primary means of mobility. Resident #2 required staff assistance to complete all activities of daily living. Resident #2 was not capable of reporting abuse.

Resident #3's diagnoses included Alzheimer's dementia and osteoporosis (thinning bones). Resident #3 was hard of hearing. Resident #3 required staff to anticipate her needs. Resident #3's care plan directed staff to speak slowly and clearly, facing the resident. Resident #3 had a history of striking out at staff, hitting, and kicking. Resident #3's care plan directed staff to offer the resident choices, calmly walk away from the resident and re-approach at another time, direct the resident away from the source of distress, provide food or fluids, assist with toileting or assist with the resident's comfort. Resident #3 resided in the secured memory care unit. Resident #3 used a wheelchair for all mobility. Resident #3 required staff assistance to complete all activities of daily living. Resident #3 required a daily aspirin which made the resident at risk for bruising and bleeding. Resident #3 was not capable of reporting abuse.

The facility's investigation revealed one afternoon the AP came to the facility to report to administrative staff that he had abused residents. The AP said the abuse occurred over the last one and one-half years of employment. The AP used excessive force during cares with the intention of harming the residents. The AP said the abuse occurred many times but he was unable to provide specific information except for Resident #1, Resident #2, and Resident #3. The AP said a few months prior to his report, he held a pillow over Resident #1's face when she was in bed for approximately five seconds. Resident #1 resisted and the AP removed the pillow. The AP said Resident #1 was able to breath with the pillow on her face. The AP said when he removed the pillow, Resident #1 called him mean. The AP said about six months prior to this report, he also roughly tossed Resident #2 into his wheelchair. In addition, the AP said during the same timeframe, he slapped Resident #3's face with an open hand. The AP said he intentionally left no marks on the residents.

When interviewed, the AP said all of the abusive treatment toward residents occurred this past summer on the night shift. The AP said he held a pillow over Resident #1's face for three

seconds. The AP said nothing in particular lead to the incident. Resident #1 did not respond and could breath. The AP said early one morning when assisting Resident #2 with cares, for no reason, the AP became angry and roughly threw Resident #2 into his wheelchair from the toilet. The AP said he intentionally threw Resident #2 to hurt him. Resident #2 made no comment but the AP said I know I hurt him. The AP said when assisting Resident #3 with cares in bed, she became upset and refused care. Resident #3 threw the washcloth at the AP. In return, the AP threw the cloth at Resident #3 and roughly shoved her against the bed. The AP covered Resident #3 with her sheets and left the room. The AP said Resident #3 made no response to his actions. The AP could not remember any additional specific incidents of resident abuse. The AP said he was not fit to care for people.

During an interview, management said the AP came in on his own to admit to physically abusing residents at the facility for the last one and one-half years. The AP said there were several incidents of physical abuse toward residents. The AP could only remember his treatment of Resident #1, Resident #2, and Resident #3.

Following the AP's report of resident abuse, the facility interviewed approximately 40 residents with no complaints of maltreatment. The facility attempted to interview Resident #1, Resident #2, and Resident #3 without success due to their limited cognition. The facility reviewed six months of quarterly satisfaction surveys completed by the residents or family members. There were no concerns of staff maltreatment addressed in the surveys. The facility reviewed incident and accident reports and vulnerable adult reports for signs of abuse. In addition, management interviewed approximately twenty staff about the AP, however because the AP was scheduled on the night shift he mostly worked by himself. The facility no longer employed the AP. In addition, management reported the AP to law enforcement.

In conclusion, abuse was substantiated. The AP admitted to physically abusing Resident #1, Resident #2, and Resident #3.

**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.

**Vulnerable Adult interviewed**: No. Resident #1 passed away. Resident #2 and Resident #3 not capable of an interview due to their cognition.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
Management provided staff education regarding their abuse and neglect policy and procedure. The facility interviewed approximately 40 residents and twenty staff who frequently scheduled with the AP. The facility reviewed six months of quarterly satisfaction surveys completed by residents or family members. The facility reviewed incident/accident reports and vulnerable adult reports for signs of abuse. The facility no longer employed the AP. In addition, management reported the AP to law enforcement.

**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
Minnesota Board of Examiners for Nursing Home Administrators
Morris City Attorney
Stevens County Attorney
Morris Police Department

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00654 | A. BUILDING: _____ B. WING _____ | C 02/03/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST WIND VILLAGE | 1001 SCOTTS AVENUE MORRIS, MN 56267 |

| (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<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5262038M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.<br><br>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.<br><br>The assigned tag number appears in the | |

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| 2 000 | Continued From page 1<br>#H5262038M, tag identification 1850.<br><br>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 "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 | far left column entitled "ID Prefix Tag." The 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."<br><br>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.<br><br>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<br><br>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 | | |

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| 21850 | Continued From page 2<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interviews, and document review, the facility failed to ensure three of three residents reviewed (R1, R2, R3) was free from maltreatment. R1, R2, and R1 were abused.<br><br>Findings include:<br><br>On February 3, 2020, the Minnesota Department of Health (MDH) issued a determination that abused 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 | No plan of correction is required. Please refer to the public maltreatment report for details. | |