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

# Office of Health Facility Complaints Investigative Public Report

**Maltreatment Report #:** H5270028M

**Date Concluded:** October 22, 2021

**Name, Address, and County of Licensee Investigated:**
White Water Health
525 Bluff Avenue
St. Charles, MN 55972
Winona County

**Facility Type: Nursing Home**

**Investigator's Name:**
Jana Wegener, 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 resident was physically abused by the alleged perpetrator (AP), facility staff, when the AP was witnessed over video repeatedly handling the resident in an aggressive manner while providing cares, and then slapped the resident across the face.

**Investigative Findings and Conclusion:**
Abuse was substantiated, and the AP was responsible for the maltreatment. The AP was witnessed on video repeatedly being rough and aggressive with the resident while providing routine cares. The AP aggressively grabbed the resident's hands and arms, then slapped the resident across the face. Additionally, one of the videos witnessed the AP covering the resident's face with her bedding while the resident thrashed around.

The investigation included interview of facility staff including licensed and unlicensed staff. The residents medical record, facility policy and procedures, employee records, and video of the AP and resident interactions were reviewed. In addition, the investigator contacted law enforcement.

The resident was admitted to the facility with diagnoses including Alzheimer's disease, dementia with behaviors, osteoporosis, aphasia (a loss of ability to understand or express speech), and major depressive disorder.

The resident's plan of care indicated she was severely cognitively impaired and required extensive assistance from staff with toileting, incontinence care, and dressing. The care plan identified the resident was at risk for being abused related to advanced age, Alzheimer's disease, dementia, impaired mobility, and dependence on staff.

When interviewed facility leadership staff stated the resident's daughter reported concerns about the AP providing cares for her mother. The family member placed a video camera in the resident's room and showed the Administrator and Director of Nursing two separate video recordings on her phone regarding the AP's interaction with the resident.

The facility investigation indicated the AP roughly handled the resident by grabbing and pulling on her, antagonized the resident by swatting at her with her bedding, slapped her in the face while providing cares, and repeatedly picked her up "like a child" and dropped her in her chair.

The administrator stated the video showed the AP roughly pulling and tugging on the resident's arms and shoulders, then grabbed the resident behind her head and quickly yanked her forward to pull her shirt down. The administrator stated when the resident leaned back, the AP made a quick swatting motion across the resident's face that looked like the AP had slapped the resident. The Administrator stated the resident's facial expression changed with her mouth dropping wide open as she swung her arm toward the AP immediately after being slapped. The Administrator stated the second video showed the AP throwing the resident's blankets over her face and leaving them there while the resident thrashed around moving her arms and legs for up to ten seconds. The administrator stated the AP's actions were very rough and abusive towards the resident.

The DON stated the videos showed the AP handling the resident very roughly, throwing her into her wheelchair then pushed her head forward. The DON stated the AP's cares were rough and abusive towards the resident.

Upon review of the video (no sound), it was observed the AP was assisting the resident to get up and dressed. The AP aggressively grabbed the resident by the side of the upper arms and picked her entire body up from laying in her bed and roughly dropped her into her wheelchair. The video showed the AP repeatedly grabbing and pulling on the resident's hands and arms in an aggressive manner while attempting to put the resident's shirt on. The AP then grabbed the back of the resident's head with his right hand and closed his fist grabbing the resident's hair and used a rapid thrusting motion to pull the resident's upper body forward, forcing her to sit at the edge of the chair as he yanked her shirt down over her back. The AP then suddenly let go of the resident's head causing her to fall backwards into her wheelchair. The resident appeared upset and crying with her mouth wide open. The video clearly showed the AP slap the resident

across her left cheek with his open right hand. The resident immediately responded by swinging towards the AP with her left hand.

When interviewed the AP denied the allegations of abuse occurred.

In conclusion, abuse was 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.

**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;
(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, deceased
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
No additional action required.

**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
Winona County Attorney

St Charles, MN City Attorney
St. Charles, MN Police Department
Minnesota Board of Nursing
Minnesota Department of Human Services

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00942 | A. BUILDING: _____ B. WING _____ | C 10/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WHITEWATER HEALTH SERVICES** | **525 BLUFF AVENUE ST CHARLES, MN 55972** |

| (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 H5270028M, 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>The assigned tag number appears in the far left column entitled "ID Prefix Tag. " | |

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| 2 000 | Continued From page 1<br>#H5270028M, tag identification 1850. | 2 000 | 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. " Following the investigators ' findings is the Time Period for Correction.<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>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 resident's physician for a specified and limited | 21850 | | 11/1/21 |

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| 21850 | Continued From page 2<br>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 one of one residents reviewed (R1) was free from maltreatment. R1 was abused.<br><br>Findings include:<br><br>On October 21, 2021 the Minnesota Department of Health (MDH) issued a determination that abuse 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. | |