Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5277062M **Date Concluded:** August 24, 2021

Name, Address, and County of Facility Investigated:
The Waterview Woods
601 Grant Ave.
Eveleth, MN 55734
St. Louis County

Facility Type: Nursing Home

Investigator's Name: Lissa Lin, RN
Special Investigator

Finding: Inconclusive

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 when the alleged perpetrator (AP) forcibly changed the resident's wet pants and underwear even though the resident told the AP he was not wet and did not want his pants changed.

Investigative Findings and Conclusion:
Abuse was inconclusive. There were conflicting accounts of whether the resident was incontinent of urine or not and whether he objected to his pants being changed or not. While the resident denied any physical injury or verbal abuse by the AP during the incident, the resident told administrative staff he felt "like he was raped and now knows how a female feels when she says no". The resident declined to go to the hospital for evaluation.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the AP and the resident's family member. The family member said interviewing the resident would cause confusion and did not want him contacted. The investigator reviewed the resident's records, the internal

investigation, staff schedules, policies, procedures, training records and enforcement documents from the Minnesota Department of Health (MDH) Licensing and Certification Department.

The resident lived at the nursing home for approximately 10 days. His diagnoses included falls, rib and hip fractures, epilepsy, dizziness and urinary retention. The resident admitted with an indwelling urethral catheter. Review of the resident's care plan indicated he had a history of confusion and required cues, orientation and supervision as needed (PRN). The resident required one staff to assist with toileting and daily assistance with perineal cares. Staff were instructed to provide incontinence products and assist in changing the resident PRN.

Review of the internal investigation documents indicated one night the resident activated his call button. The AP went to the resident's room. The AP said the resident asked for ice water and skin cream. When she returned with the ice water, the AP found the resident's incontinence pads, adult brief, and bedding were soaked with urine. The AP indicated she changed the resident's wet pants and bedding with no protest from the resident.

The next day the resident reported to a nurse manager that he had been forced to change his dry, unsoiled pants against his will. The resident could not identify the staff person by name. The resident indicated he felt violated but also safe at the nursing home.

During an interview, the AP said she was a corporate float staff member and did not know all the incontinent residents on her assigned floor that night. The AP said she responded to the resident's call light, and he told her needed to use the bathroom. She helped him to the toilet from his recliner and saw his pants and underwear were wet with urine. She told the resident he needed changing and proceeded to change him into dry, clean underwear and pants. The AP assisted the resident back to his recliner without incident.

During an interview with MDH licensing staff, the AP said she may have confused residents. The AP said she did answer a call light and could not figure out what the client wanted: ice or medication. She checked him; he was not wet and did not need to use the toilet. The AP said she had vulnerable adult abuse training when she was hired at the nursing home and received abuse retraining after the incident. The AP said she quit working at the nursing home for personal reasons.

During an interview, the social services director (SD) said she met with the resident to document his concern. She believed the incident happened. The SD also said she did not know the AP or anything about her work history.

During an interview, a nurse manager said she sees the resident daily because his room is near her office. She said the resident does not appear negatively affected or changed after the incident.

During an interview, the resident's family member (FM) said he is notified of any issues or changes involving the resident, including this concern. The FM said the resident has incontinence problems and increasing confusion and can get angry with staff quickly for no reason. The FM said the resident talked about the alleged incident only once and he told the resident that staff can't let him sit in wet pants, he needs to be changed. The FM said he is happy with the staff and the cares the resident receives and is not sure the incident occurred.

In conclusion, it was inconclusive whether abuse occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, family member/POA asked investigator not to interview him due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Conducted an internal investigation
Retrained staff
AP no longer employed at facility

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. 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.

cc: The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00583	A. BUILDING: _____ B. WING _____	C 03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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: On 3/17/21, through 3/19/21, a standard abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be OUT of compliance with the MN State Licensure. The following complaints were found to be	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID	

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2 000	Continued From page 1 SUBSTANTIATED: H5277054C (MN70916) with a licensing order issued at MN Rule 1980. H5277056C (MN57933) with no licensing orders issued. H5277057C (MN59822) with no licensing orders issued. H5277059C (MN60556) with no licensing orders issued. H5277060C (MN67751) with no licensing orders issued. H5277061C (MN49088) with no licensing orders issued. The following complaints were found to be UNSUBSTANTIATED: H5277058C (MN64033) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000	Prefix Tag." The state statute/rule out of compliance is 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 evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have 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 to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a	21980		4/6/21

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21980	Continued From page 2 vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or	21980		

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21980	Continued From page 3 directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 1 of 7 residents (R1) reviewed for abuse. Findings include: R1's Transfer/Discharge Report printed 3/22/21, indicated R1's diagnosis included non-displaced fracture of posterior wall of right acetabulum with routine healing (hip fracture), and humerus fracture. R1's admission Minimum Data Set (MDS) dated 3/8/21, identified R1 was cognitively intact, had clear speech, was able to understand others and be understood. R1's MDS further indicated he required extensive assistance of one with transfers, walking, dressing, toilet use, and personal hygiene. R1's MDS further indicated he was always continent of bladder. R1's care plan initiated on 3/2/21, indicated R1 had a self-care deficit, and would be dressed, groomed, and bathed per his preferences. On 3/12/21, at 1:43 p.m. a facility incident report submitted to the SA indicated R1 had reported a staff, nursing assistant (NA)-A, answered his call	21980	F 600 Free from Abuse and Neglect Immediate Corrective Action: NA-A no longer works for facility. Corrective Action as it applies to others: The Policy for Abuse Prohibition/Vulnerable Adult Plan was reviewed and remains current. All staff received education regarding Abuse Prevention/Prohibition specific to reporting, listening to resident concerns and refusals of cares. Administrator, Administrator Designee, Director of Nursing, Nurse Manager and Social Worker were educated on the investigative process to include removing any staff member(s) named as an alleged perpetrator from the floor until the investigation is completed and course of action is determined. Date of Compliance: 4/6/21 Recurrence will be prevented by: The Administrator or designee will complete 5 audits on staff knowledge 5 times/week x 2 weeks, weekly x 4 weeks and then monthly x 3 months. Audits will consist of staff knowledge questions regarding abuse prevention and reporting. QAPI Committee will review for ongoing audits. The Social Services Director or Designee	

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21980	Continued From page 4 light at approximately 4:00 a.m. R1 wanted help pulling up his underwear and pants after putting lotion on his legs. R1 reported NA-A felt his pants, then went to grab a new pair of pants and a shirt from his closet. R1 told NA-A he did not urinate and was not wet, and he told NA-A to stop. R1 stated she continued to change him. R1 reported that he felt like he was raped, and he now knows how a female feels when she says stop. On 3/18/21, at 9:07 a.m. social worker (SW)-A was interviewed. SW-A stated on 3/12/21, the director of nursing (DON) came to her and told her R1 had some concerns. SW-A spoke to R1, who told her what occurred. SW-A stated R1 told her he knew how a woman must feel when raped by a man when she tells him no. -at 9:21 a.m. the DON was interviewed. The DON stated the morning of 3/12/21, a staff person reported to her that R1 was upset, and said a night staff person forcibly removed his clothes. The DON stated the staff person told her R1 said he knew how a woman must feel when raped by a man when she tells him no. The DON said she reported this to the SW and the nurse consultant (NC). The DON said she did not think about removing NA-A from the schedule that day pending investigation, and she was not aware when NA-A worked again. The DON stated she did talk to R1 at a later date, and he told her he knew how a woman must feel when raped by a man when she tells him no. On 3/19/21, at 10:54 a.m. the DON was interviewed. The DON stated when there was an allegation of abuse, the first step was to ensure the safety of the resident, and if an employee was the alleged perpetrator, they would be removed from the facility pending an investigation. The	21980	will complete 5 audits with 5 residents 5 times/week x 2 weeks, weekly x 4 weeks, and then monthly x 3 months. Audits will consist of questions to the resident regarding specifically if they feel safe in the facility, do they have any concerns that they would like us to know about, do they have any concerns related to their care, do they have any concerns with how employees treat them, and is there anything else they would like to share. QAPI Committee will review for ongoing audits.	

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21980	Continued From page 5 DON stated the administrator would need to be notified, and the report to the State Agency (SA) would need to be made within two hours. No explanation of why the abuse was not reported was provided. -11:03 a.m. SW-A was interviewed. SW-A stated staff need to report abuse immediately to the DON and the administrator. SW-A did not provide an explanation of why the abuse was not reported within two hours. -at 11:25 a.m. the administrator was interviewed. The administrator stated staff need to report allegations of abuse immediately to their immediate supervisor. The facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, directed all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. The policy further identified the immediate supervisor will be notified immediately. The policy directed if the abuse is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy further directed staff to report suspected abuse to the Office of Health Facility Complaints (OHFC) not later than two hours after forming the suspicion of abuse. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility	21980		

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21980	Continued From page 6 should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		