Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52819882M
Compliance #: H52815820C

Date Concluded: April 17th, 2025

Name, Address, and County of Licensee Investigated:
Valley Care and Rehab LLC
600 5th Street SE
Barnesville, MN 56514
Clay County

Facility Type: Nursing Home

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
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) emotionally abused the resident when the AP made a social media post with a picture of the resident's hand covered in liquid stool on it after the resident's colostomy bag leaked. The photo was captioned "My 13th reason why" (a reference to a television show about what drove a student to commit suicide)

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP made the social media post which could be expected to produce emotional distress, be disparaging, derogatory, and/or humiliating. The AP was aware of expectations for social media use and using cell phones at work and had a history of disciplinary action related to inappropriate social media posts at work.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, personnel files, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve problems), arthritis, and depression. The resident's service plan included assistance with all activities of daily living. The resident's assessment indicated the resident had an indwelling urinary catheter and colostomy (a surgical procedure that creates an opening in the abdomen for feces waste to exit the body). The resident required staff assistance to manage catheter and colostomy care. The resident had moderately impaired cognition.

The facility's internal investigation indicated management received a call from police and a citizen in town regarding a social media post made by the AP. The internal investigation included a copy of the picture posted to Snapchat which showed the resident's right hand with liquid stool on it, a catheter bag on the floor and the resident's colostomy bag which had leaked. The caption to the photo was "my 13th reason." The AP's name was at the top of the photo and indicated it had been posted two hours ago. Management spoke with the AP who initially denied making any social media posts but when she was told about the evidence, she admitted to management that she had posted something to her private story. The AP stated she took it down when she realized it was inappropriate. The AP attributed a rough night before her shift to have influenced her decision making.

The AP's employee record indicated the AP had been educated multiple times on the facility's social media policy and that she agreed to comply with the policy. The AP had received two prior verbal warnings regarding using her cell phone at work and for using Snapchat at work. The first disciplinary action indicated the AP was using Snapchat "without regard to who was in the background." The second disciplinary action indicated the AP posted a picture to social media of herself with diarrhea covered pants in a utility room with a caption "what a shitty Friday" with the AP's thumbs up. The AP was informed the picture was unprofessional and many companies would consider posting a picture like that to any online platform as grounds for termination. The AP replied to management that she "did not agree it was unprofessional and only wanted to know who had shown it to this writer." Management explained to the AP that she was expected to stop posting things of that nature from the facility. Both times, the social media policy was reviewed with the AP.

When interviewed by a previous federal evaluator, the AP stated she used her cell phone while caring for the resident in his room. The resident's colostomy bag had exploded, and she took a picture of the feces, his hand, colostomy, the bed, floor, and part of his bare leg. The AP didn't think family could have identified him in the picture since his face wasn't pictured. The AP confirmed she posted the picture while she was at work and that she removed it an hour later because she was ashamed, embarrassed, it was unprofessional, and she let her emotions get

the best of her. The AP told the federal evaluator she knew what she was doing, did it anyway, and regrets it. The AP stated if the resident knew it had been taken and posted on social media, it would have affected him negatively, he would have felt embarrassed, and it was an invasion of his privacy. The AP was not able to recall any past write ups regarding issues with her use of cell phones at work and social media posts.

When interviewed by the investigator, the AP stated on the night she took the picture, she had one of the worst nights she had ever worked and several residents on her group wanted to get ready for bed at the same time. The AP stated she got frustrated because several rooms did not have the items she needed stocked so she had to frequently run back and forth. When she got to the resident's room, his room also lacked the necessary supplies and when she finally started getting him ready, she heard a "splat" followed by the resident saying oh no and when she turned around, she saw his colostomy bag had exploded everywhere. The AP stated it was completely out of character for her, but she took her phone out and took a picture of the exploded colostomy bag and posted it to her private story on Snapchat. The AP stated she took it down after an hour because she looked back and thought ok, this is stupid, it's nothing I'd normally do so she deleted it. The AP stated she didn't think the picture would be humiliating to the resident, maybe a little embarrassing. The AP stated she felt awful about the incident, and it was very out of character for her to do something like that.

When interviewed by a previous federal evaluator, facility management stated the AP had previously taken a picture with her cell phone along with another staff member at work and there was a resident behind her in the photo. The AP had taken a picture with her cell phone in a utility room by herself, held up resident's pants soiled with stool, and posted it to social media. Education was provided and included facility policy and expectations. Management stated the AP made a poor choice in the moment, had taken a photo of a resident, posted it to social media which would affect privacy and dignity. The AP was noted to be immature, knew what she did was wrong, and used poor decision making that led her to take the picture. Management confirmed that cell phones were not to be used during work and that staff were aware of the facility's social media policy.

In conclusion, the Minnesota Department of Health determined 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: …
(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: Unable due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The AP was terminated.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

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
Clay County Attorney
Barnesville City Attorney
Barnesville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00968	A. BUILDING: _____ B. WING _____	C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 #H52819882M/#H52815820C, 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	

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2 000	Continued From page 1 #H52819882M/#H52815820C, 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." 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 resident's physician for a specified and limited period of time, and only when necessary to	21850		

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21850	Continued From page 2 protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		