Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5339026M **Date Concluded:** September 20, 2021

Name, Address and County of Facility:
Mother of Mercy Senior Living
230 Church Street Box 676
Albany, MN 56307
Stearns County

Facility Type: Nursing Home **Evaluator's Name:** Yolanda Dawson, 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 perpetrators emotionally abused the resident when she on multiple occasions placed a broom under the resident's wheelchair to restrict her mobility.

Investigative Findings and Conclusion:
Abuse was substantiated. The alleged perpetrators (AP) were responsible for the maltreatment. Two staff members repeatedly restricted the resident's mobility during mealtime to keep her at the table by placing a broom behind the wheels of her wheelchair. The restraint caused the resident to become distressed and cry.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed video still shots, resident and personnel records, and internal investigation documentation. The investigation included a review of facility restraint policies and procedures.

The resident resided on the memory care unit with diagnoses that included Alzheimer's disease. The resident was dependent on staff for all cares and used a mechanical lift for transfers.

According to documents provided by the facility, one evening, a nurse entered the memory care unit while some residents sat at a dining room table eating dinner. The nurse saw a broom on the floor blocking the back wheels of a resident's wheelchair. At one a point the resident became upset and started to cry because she could not move her wheelchair. The nurse removed the broom and consoled the client. After the nurse talked to staff, she found the practice of restricting the resident's movement with the broom had been occurring for a long time.

Review of video still shots provided by the facility indicated six different days during which AP #1 and AP #2 placed the broom behind the wheels of the resident's wheelchair. On one occasion, the still shot showed the resident leaning over her wheelchair reaching for the broom. During the same six days, there were twelve staff members that saw the broom and either adjusted or walked around the broom.

During an interview, the Assistant Director of Nursing (ADON) stated the resident liked to wheel herself around the unit, and she did not exit seek or try to enter other people's space. She stated received a report the resident became upset and started to cry when she tried to move her wheelchair and could not because the broom was blocking the wheels. The ADON stated that during an internal investigation interview with AP #2, she stated staff was doing this so they would not have to get the resident and bring her back to the table.

During an interview, AP #1 stated the resident spent most of her day wheeling herself around the unit and happy most of time and she was generally happy. She stated she placed the broom on the floor behind the resident's wheels to keep her at the table to eat. AP #1 stated she saw AP #2 do this and believed it was common practice. AP #1 stated she did not think she was doing anything wrong as it was a way to ensure the resident was eating, and she had seen other staff members do this.

During an interview, AP #2 stated she started the practice of placing the broom behind the wheels of the resident's wheelchair approximately two months ago. She stated she knew it was a restraint but did not think it was that bad because she was trying to get the resident to eat. AP #2 stated the resident would sometimes reach down and try to remove the broom but did not appear to be in distressed. AP #2 stated that when the resident finished eating, they would remove the broom and let her go.

In conclusion, emotional abuse was substantiated. The staff had a practice of unreasonably confining the resident by placing this improvised restraint. There was no order for the restraint, nor was there any emergency or safety issue which required the restraint.

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;
(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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Vulnerable Adult interviewed: No, unable due to cognitive decline.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and provided retraining for staff members.

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
Stearns County Attorney
Albany City Attorney
Stearns County Sheriff's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00634	A. BUILDING: _____ B. WING _____	C 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307**

(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 #H5339026M, 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/27/21

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2 000	Continued From page 1 #H5339026M, 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. Relates to deficiency issued under 65JE11.	2 000		
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	21850		7/27/21

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21850	Continued From page 2 others. This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. R1 was emotionally abused. Findings include: On June 4, 2021, the Minnesota Department of Health (MDH) issued a determination that emotional abuse occurred, and that the facility 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. REVIEWED.	