Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: H5494058M
Compliance #: H5494050C

Date Concluded: February 10, 2021

Name, Address, and County of Licensee Investigated:
Elim Home
701 1st Street
Princeton, MN 55371
Mille Lacs County

Facility Type: Nursing Home

Investigator's Name:
Paul Spencer, 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 alleged perpetrator (AP) abused Resident #1 when the AP grabbed her wrists and spoke harshly to her.

Investigative Findings and Conclusion:
It was inconclusive whether abuse occurred. The AP did not deny grasping the resident's wrists but stated she did so to prevent Resident #1 from striking her while redirecting Resident #1 away from another resident. There was not a preponderance of evidence whether the incident met the definition of abuse.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of the resident's medical record. The investigation included an interview with the AP.

Resident #1's diagnoses included Alzheimer's disease. Resident #1 resided on the facility's memory care unit. The resident's care plan indicated she had behaviors such as hitting and grabbing at staff, along with wandering in other resident's rooms. Her care plan indicated she walked independently with her walker.

Resident #2's diagnoses included dementia, obsessive-compulsive disorder and anxiety. Resident #2's care plan indicated she was independent with walking and toileting.

Resident #3's diagnoses included dementia and anxiety. The resident's care plan indicated Resident #3 required assist of two staff members for transfers with a transfer belt and used a wheelchair for mobility.

One evening, a staff member witnessed the AP, another staff member, holding Resident #1's wrists. The staff member intervened, separated the AP from Resident #1 and reported the matter to the nursing supervisor, who sent the AP home on administrative leave. The facility conducted an investigation, provided disciplinary and educational follow-up with the AP, and allowed the AP to return to work.

During an interview, the director of nursing (DON) stated she interviewed the AP regarding the incident with Resident #1. The DON stated the AP said she was redirecting Resident #1 because Resident #1 was inappropriately trying to toilet another resident, but Resident #1 became upset, attempted to strike the AP, and the AP held the resident's wrists to protect herself. The DON stated Resident #1 did have a history of inappropriately offering assistance to other residents and at times striking out. The DON stated she provided the AP with education and coaching on ways to better handle situations like this and allowed the AP to return to work. The DON also stated the facility completed an internal investigation, which included asking residents if they had any concerns with the caregivers grabbing them or speaking rudely to them; all the residents denied any concerns. One of those residents, Resident #2, later reported she witnessed the AP grab and used a "mean" voice with another resident, (Resident #3). The DON stated when the facility investigated this concern, Resident #3 showed no signs of injury. The DON stated the facility's investigation was limited due to Resident #3's impaired cognition. The DON stated the AP denied grabbing or speaking inappropriately to Resident #3. The DON stated the AP no longer works at the facility.

During an interview, the first staff member stated she witnessed the AP holding Resident #1's wrist while the two struggled with each other. She stated the AP yelled at Resident #1. She stated she immediately separated the AP and Resident #1. The AP threw her arms up and walked away, while she guided Resident #1 to the nearest bathroom and comforted Resident #1 because she looked scared. The staff member stated she informed the nurse what happened.

During an interview, the nurse stated an unlicensed staff member reported the incident to him. The nurse stated he assessed Resident #1 immediately but found no injury; he stated Resident

#1 demonstrated no recall of the incident. The nurse stated he sent the AP home while the facility conducted an internal investigation.

During an interview, the AP stated she was trying to redirect Resident #1 from entering another resident's room, when Resident #1 began trying to hit her, which is why she was holding Resident #1's wrists. The AP stated she did not yell at Resident #1 but did her raise her voice during the incident. The AP stated it probably looked bad from the other staff members' point-of-view. The AP stated the nurse sent her home, and she was allowed to return to work after an interview and re-education with the DON. The AP stated she did not speak loudly or grab Resident #3. The AP stated she no longer works at the facility.

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. Resident #1 was deceased; Resident #3 was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and initiated additional education for employees regarding abuse prevention and providing re-direction.

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