Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5512041M **Date Concluded:** September 17, 2021

Name, Address, and County of Licensee Investigated:
First Care Living
900 Hilligoss BLVD SE
Fosston, MN 56542
Polk County

Facility Type: Home Care Provider

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 repeatedly verbally abused over several minutes when the alleged perpetrator (AP), facility staff, swore at and used abusive language toward the resident when assisting the resident with incontinent cares.

Investigative Findings and Conclusion:
Maltreatment is substantiated. The alleged perpetrator was responsible for the maltreatment. Two facility staff witnessed the AP verbally abuse the resident (R1). In addition, prior to the incident, the AP was reported to have recurring abusive behaviors toward four other residents in the facility, R2, R3, R4, and R5.

The investigation included interviews with facility staff members, including leadership staff, nursing staff, and unlicensed staff. The resident medical records, facility incident/grievance reports, facility documentation, staff training, and the AP's personnel files were reviewed.

R1 was admitted to the facility with diagnoses including Alzheimer's Disease, dementia with behavioral disturbances, anxiety disorder, and depression.

R1's medical record indicated the resident had cognitive impairment and had behaviors related to Alzheimer's, dementia, and anxiety disorder making the resident susceptible to abuse. The client was incontinent and required extensive assistance from staff with incontinence care.

The facility summary of events indicated while two staff were assisting R1 with incontinent cares they requested the AP's assistance. The two staff indicated the AP stood in R1's doorway prior to entering the room and said "ewwww do I really need to help, this fucking stinks so bad!" While the AP was assisting with incontinence care the AP asked R1 "why do you have so much fucking poop on you; this is ridiculous; shut the fuck up, you're not in fucking pain!"

When interviewed the two facility staff who witnessed the verbal abuse stated the AP continued to swear at R1, telling the resident "This is disgusting, you fucking stink so bad", and yelled at the resident "shut the fuck up, you're not hurting, you are just being a baby!" Both staff indicated the verbal abuse was continuous and the AP repeatedly swore and made abusive statements to the resident over and over again for approximately 5-10 minutes while assisting with incontinence care. One staff stated R1 was crying much louder than usual, and the resident was not able to be redirected or comforted. The staff member stated the incident was shocking, very upsetting, and made her cry.

The AP's personnel files indicated there were multiple coaching, resident grievances, and emails from staff reporting concerns with the AP's conduct with residents including the following:

R2's medical record indicated he was admitted to the facility with diagnoses including cancer of the prostate, and spinal stenosis. The record indicated he was cognitively impaired and susceptible to abuse. A resident progress note indicated while asking for a pillow for his feet, R2 reported to the staff he had not asked the AP for help because "she gets sassy". A resident grievance form was completed by R2 regarding the incident indicating the AP was, "rough and crabby with him" and he had told her to "leave his room". A month later another resident grievance form indicated R2 reported the AP had made inappropriate verbally rude comments, was short with him, and rude. The coaching session following the reports indicated the AP stated she was "Sick of being called into the office" and was "trying to watch her mouth".

A staff email reported staff witnessed the AP tell R2 to "shut the fuck up," while the AP was assisting R2's roommate. The AP told both residents she was "sick of them being mean to her."

R3's medical record indicated he was admitted to the facility with diagnoses including stroke, major depressive disorder, chronic pain, and anxiety disorder. The record indicated R3 had physical and cognitive deficits causing him to be susceptible to abuse. A staff coaching form indicated the AP was reported by another staff who witnessed the AP loudly scold R3 like a child for getting out of bed.

R4's medical record indicated he was admitted to the facility with diagnoses including Parkinson's disease, Alzheimer's disease, and dementia without behavioral disturbances. The record indicated R4 had cognitive impairment and was susceptible to abuse. An undated handwritten note from staff reported the AP was witnessed making inappropriate jokes, swearing, and roughly handling R4 during cares.

R5's medical record indicated the resident was admitted to the facility with diagnoses including Alzheimer's Disease and dementia without behavioral disturbances. The record indicated she was cognitively and physically impaired making her susceptible to abuse. An employee coaching form indicated the AP was heard loudly and sternly telling R5 "You need to sit, sit right here, I told you to sit, were not playing this game!"

When interviewed the AP stated she had no complaints about her conduct with residents including accusations of verbally abusive language and rough handling of a resident during cares and did not recall verbally abusing R1.

In conclusion, verbal abuse was substantiated. The AP had a history of ongoing abusive behavior with residents in the facility, leading up to the incident when the AP was witnessed by two staff verbally abuse R1.

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:
(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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

The AP is no longer employed by the facility. The facility resident protection vulnerable adult policy was revised, and facility staff received education on the updated reporting, and resident protection aspects. 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. 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
City Attorney of Henning Minnesota
Polk County Attorney
MN Board of Nursing – Nursing Assistant Registry
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00461	A. BUILDING: _____ B. WING _____	C 09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 #H5512041M, 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		10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 #H5512041M, 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 "corrected" 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		
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 others.	21850		9/17/21

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21850	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one resident (R1) reviewed was free from maltreatment. R1 was verbally abused when a facility staff swore and used abusive language toward R1 repeatedly over several minutes. Findings include: On September 17, 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 investigator concluded there was a preponderance of evidence that maltreatment occurred.	21850	Corrected	