MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Atwood ICF-IID		**Report Number:** HG163001	**Date of Visit:** March 1 and 2, 2017
Facility Address: 110 5th Street North		**Time of Visit:** 10:45 a.m. to 5:00 p.m. 7:30 a.m. to 11:00 a.m.	**Date Concluded:** April 24, 2017
Facility City: Atwater		**Investigator's Name and Title:** Jill Hagen, RN, Special Investigator	
State: Minnesota	**ZIP:** 56209	**County:** Kandiyohi	

☒ **ICF/IID**

Allegation(s):

It is alleged that a client was emotionally abused when the alleged perpetrator (AP) AP #1 inappropriately instructed the client to urinate on the floor. In addition, it is alleged that the client's privacy was violated when AP #2 made an inappropriate video of AP #1's interactions with the client.

☒ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)

☒ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when AP #1 used derogatory and demeaning language directed at the client while assisting the client during toileting and when the AP #1 kicked the client's foot. A violation of the client's privacy rights is not substantiated. Although AP #2 took a video of AP #1's interaction with the client; the video was to prove AP #1's inappropriate actions. The video was shown to AP #2's supervisor, not shared with any other individual, and deleted according to the supervisor's request.

The client's diagnoses included Downs Syndrome and early signs of dementia. The client often was easily distracted and required staff prompts to complete tasks. The client required the assistance from staff and the use of a walker to ambulate. The client required one to two staff to assist with toileting every two to four hours. The client was not able to communicate his/her needs to others. The client was susceptible to abuse in part due to the inability to recognize and report abuse.

Early one evening, AP #1 assisted the client to ambulate to a dining room chair for the meal. The client was slow to sit in the chair. AP #2 witnessed AP #1 draw back on of the AP's legs and then kick the client in the lower leg/ ack of the shoe. The client responded loudly saying "ouch." There was no documentation of the incident.

Later that evening, AP #2 used a personal cell phone to take a video of AP #1's interaction with the client in the common bathroom. AP #1 assisted the client to sit on the toilet. At that time, AP #1 said in a loud voice, "You're not going to piss on the floor like you did yesterday. You're going to sit down, you're going to relax, and you're going to go to the bathroom, not on the floor cause I'm not wiping up your crap anymore". At that time, the AP#1 placed toilet paper in front of the client's groin. The client responded yelling "No. Ow." AP #1 made a loud huffing noise and the video ended.

During an interview, AP #2 said she witnessed AP #1 draw her foot back then intentionally kick the back of the client's ankle/shoe. When AP #1 realized AP #2 witnessed the actions AP #1 looked "panicked" but made no comment. AP #2 reported the incident immediately to the supervisor. After AP #1 kicking the client when slowly sitting down, AP #2 did not trust AP #1 to toilet the client alone. AP #2 used a personal cell phone to video tape the interaction to provide evidence of AP #1's treatment of the client.

During an interview, AP #1 said s/he was frustrated and angry that evening. AP #1 did not get along with the client. AP #1 kicked the back of the client's foot but stated it wasn't intentional. AP #1 was tired, spread s/he legs apart to stretch, and kicked the client either on the sole of the shoe or back of the ankle. AP #1 stated the comments AP#1 made in the bathroom shouldn't have been said and the client had a right to be treated better.

AP #1 was suspended from the facility that evening and terminated from employment.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☒ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility trained all staff including AP #1 regarding respectful treatment of clients. AP #1 received training on abuse, neglect, and what constitutes abuse.

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.

Compliance

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) – Compliance Met

The facility was found to be in compliance with Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I). No deficiencies were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) - Compliance Not Met
The requirements under State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Following the incident, the facility terminated the employment of alleged perpetrator #1. The facility providing training on the vulnerable adult policy and procedure and how to report any concerns with staff treatment of clients. All staff had received the training at the time of the on-site investigation. Staff training include client privacy rights. The facility provided and documented random audits of care provided by staff to the clients.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"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;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Facility Incident Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan
- [x] Other, specify:

Other pertinent medical records:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Four

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ○ No ◉ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date: Time: Date: Time: Date: Time:

_____ _____ _____ _____ _____ _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date: Time: Date: Time: Date: Time:

_____ _____ _____ _____ _____ _____

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Meals
☒ Incontinence
☒ Other: Visited DAC

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A
Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Mental Health and Developmental Disabilities

Atwater Police Department

Kandiyohi County Attorney

Atwater City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G163	A. BUILDING _____ B. WING _____	C 04/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATWATER ICF-IID	110 5TH STREET NORTH, BOX 355 ATWATER, MN 56209

(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) COMPLETION DATE
W 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #HG163001. Atwood ICF-IID is in compliance with 42 CFR Part 483 Subpart 1, Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7015 1520 0002 9402 0651

June 18, 2017

Ms. Brenda Streich, Administrator
Atwater ICF-IID
110 5th Street North, Box 355
Atwater, MN 56209

Re: Enclosed State Licensing Order and Federal Certification Results - Complaint Number HG163001

Dear Ms. Streich:

On April 12, 2017, a complaint investigation and abbreviated standard survey were completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints for the purpose of assessing compliance with state licensing rules in accordance with the Vulnerable Adults Act related to complaint number HG163001 and federal certification regulations for Intermediate Care Facilities for Individuals with Intellectually Disabilities (ICF/IID). At the time of the investigation, the investigator noted one State licensing violation:

St - 5 - 0700 - Mn Statute 144.651 Subd. 14. - Res. Rights Freedom From Maltreatment.

The investigation found no Federal certification deficiencies during the abbreviated standard survey. Refer to the enclosed form CMS-2567, for the results of this visit.

The State licensing order is delineated on the attached Minnesota Department of Health State form. The form should be signed and returned to this office when the order is corrected. We urge you to review the order carefully, and if you find that the order is not in accordance with your understanding, you should contact Annette Winters at the phone number or email listed below. A written plan for correction of licensing order is not required. The signed form can be returned to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: Annette.M.Winters@state.mn.us
Phone: (651) 201-4201
Fax: (651) 281-9796

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement.

Please note, it is your responsibility to share the information contained in this letter and the results of the visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health

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	01110	A. BUILDING: _____ B. WING _____	R-C 07/31/2017

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{5 000}	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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.	{5 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 30, 2017

Ms. Brenda Streich, Administrator
Atwater ICF/IID
110 5th Street North, Box 355
Atwater, MN 56209

RE: Complaint Number HG163001, Licensing Follow-up

Dear Ms. Streich:

On July 31, 2017, an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a revisit related to licensing orders issued on April 12, 2017.

The investigator found that licensing orders issued as a result of the investigation have been corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. A complaint investigation was conducted to investigate complaint #HG163001. As a result of the investigation, the following correction order is issued.	5 000	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 Supervised Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule	

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5 000	Continued From page 1	5 000	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 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.	
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS 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 nontherapeutic 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 nontherapeutic 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.	5 700		

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5 700	Continued From page 2 This MN Requirement is not met as evidenced by: Based on document review and interviews, the facility failed to ensure a client was free from abuse for one of three (C1) clients reviewed for abuse. Findings include: Review of C1's medical record revealed C1's diagnoses included Down's Syndrome. C1 required the assistance from one to two staff for toileting and one staff for meal set-up. C1 required staff assistance and the use of a walker to ambulate. Staff were directed to be patient with C1 and prompt him to complete tasks to maintain a level of independence. C1 had difficulty communicating his needs to others. Review of the facility's Incident Report form signed on 1/20/2017, indicated on 1/11/2017, at 7:00 p.m. human service technician (HST)-A took a video with her cell phone of an interaction between HST-B and C1. On the video, HST-B was assisting C1 to use the toilet in the common bathroom. With C1 sitting on the toilet, HST-B said to C1, "You're not gonna piss on the floor like yesterday. You're gonna sit down, you're gonna relax, and you're gonna go to the bathroom and not on the floor cause I'm not wiping up your crap anymore." HST-B's statements were made with a stern tone of voice. C1 appeared agitated by the comments. An interview with the administrator and compliance monitoring staff (CM) on 3/1/2017, at 12:15 p.m., revealed on 1/11/2017, before the	5 700		

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5 700	Continued From page 3 evening meal, HST-A reported concerns with the treatment provided to C1 by HST-B, to the program director (PD). HST-A witnessed HST-B being inpatient and using a "harsh" tone when attempting to assist C1 into a chair. HST-B lifted her leg backwards and "tapped" the side of C1's foot. On 1/16/2017, HST-A showed the administrator a video recorded on her cell phone of HST-B assisting C1 with toileting. On the 14 second video, HST-B was inpatient with C1 and made inappropriate statements to C1. HST-B did not treat C1 with respect as trained. C1 responded with agitation by yelling at HST-B. When interviewed on 3/21/2017, at 3:07 p.m. HST-B stated she worked the evening of 1/11/2017, with HST-A. HST-B said accidentally kicked C1 in the foot when assisting him into the dining room chair. HST-B brought her leg back and kicked C1 on the bottom of a foot. After the evening meal around 7:00 p.m. HST-B assisted C1 to the bathroom. C1 refused to get off the toilet despite multiple attempts. C1 kept repeating "stop." HST-B said she was frustrated and angry and took it out on C1. HST-B said she never got along with C1 but she had no right to treat C1 that way. An interview with HST-A on 3/23/2017, at 12:09 p.m. established she worked the evening of 1/11/2017, with HST-B. HST-A said when getting the client's to the table for the evening meal she witnessed HST-B kick C1 on the foot. HST-B brought her leg back and intentionally kicked C1. C1 responded by saying "ouch" in a loud voice. HST-A did not see exactly where C1 was kicked, either the back of his shoe or foot. After the meal, around 7:00 p.m. HST-A took a video on her cell phone of HST-B's treatment of C1. HST-A wanted to provide evidence to her supervisor of HST-B's	5 700		

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5 700	Continued From page 4 behavior toward C1. The video was only shared with HST-A's supervisor. An attempt was made to interview C1 on 3/1/2017, at 3:30 p.m. C1 was not able to provide information on the incident. Review of the facility's policy and procedure titled Maltreatment of Vulnerable Adult and not dated, referred to the Minnesota Statutes 2015, 626.5572. The statute defined abuse as conduct which was not an accident or therapeutic conduct which produced or could reasonably be expected to produce physical pain or injury or emotional distress including but not limited to; 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. Review of the facility policy and procedure titled Conduct Toward Clients not dated, stated, conduct between staff and clients would promote each clients growth, development and independence. Staff will treat all clients with respect and dignity in all areas of daily living. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	5 700		