DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL20935026M **Date Concluded:** October 5, 2021

Name, Address, and County of Licensee Investigated:
Westwood of Duluth
925 Kenwood Avenue
Duluth, MN 55811
St Louis County

Facility Type: Home Care Provider **Investigator's Name:** Carol Moroney, 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 client was abused when the alleged perpetrator (AP), facility staff, restrained the clients' arms when attempting to get the client's blood pressure. The client resisted and attempted to hit, "head bump" and kick the AP.

Investigative Findings and Conclusion:
Abuse was substantiated. The AP was responsible for the maltreatment.
The AP was seen forcefully restraining the client's arms when attempting to obtain a blood pressure from the client. The client did not want her blood pressure taken and was struggling with the AP for approximately five minutes until another staff member told the AP to stop.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The clients medical record, facility policy and procedures, staff training, and prior facility incident reports were reviewed.

The client's medical record indicated the client had diagnoses including Alzheimer's disease, Dementia, and depression. The client's signed service agreement indicated the client received

daily services and assistance with dressing and bathing. The staff were directed to use a calm, quiet approach, use two staff if the client was resistive or combative, and behavior triggers for the client were noise or crowded areas.

The facility investigation indicated the AP approached the client who was sitting in the wheelchair in the common area. The AP placed the blood pressure cuff on the client's arm. The client became resistive and was attempting to hit, kick, and head butt the AP. The AP "aggressively" held the clients arms down as the client attempted to struggle. A staff member observed the interaction and asked the AP to let go of the client and step away. The AP did not stop the first time and was asked again to let go of the client. The AP let go of the client and walked away.

The facility records indicated after the incident a physical assessment noted the client had redness on the posterior of her left forearm and left arm. The client refused any further assessment at that time.

A video of the incident (no sound) showed the AP approach the client with a vital sign machine. The AP applied the blood pressure cuff to the clients right upper arm and started the machine which caused the blood pressure cuff to tighten. The client reached over to the cuff and the AP grabbed onto the clients' arms and held them down. The client continued to struggle and attempted to kick, and head bump the AP, however, the AP continued to restrain the client. This continued for approximately five minutes until another staff member came over and appeared to say something to the AP. The AP forcefully grabbed the vital sign machine and quickly walked away.

When interviewed a facility witness indicated she saw the AP being "very aggressive" to the client. The staff member stated she had to ask the AP two times to step away from the client.

When interviewed the AP stated she was aware two staff should be helping the client due to her behaviors. The AP stated staff were busy, so she attempted to get the clients blood pressure without another staff assisting. The AP stated she restrained the client so she could obtain the clients routine blood pressure check.

In conclusion, abuse was substantiated. The alleged perpetrator was responsible for the maltreatment.

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

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825

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

Action taken by facility: No further action.

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.

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 Mental Health and Developmental Disabilities
St Louis county attorney
Duluth city attorney
Duluth Police department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20935	A. BUILDING: ___ B. WING ___	C 09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	**925 KENWOOD AVENUE DULUTH, MN 55811**

(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
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to an investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 27, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20935026M. At the time of the investigation, there were #47 clients receiving services under the comprehensive license. The following correction order is issued for #HL20935026M, tag identification 0325.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On October 5, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person 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.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	