Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HZ343002M

Date Concluded: October 11, 2022

Name, Address, and County of Licensee Investigated:
Avera Granite Falls Care Center
345 10th Avenue
Granite Falls, MN 56421
Yellow Medicine County

Facility Type: Nursing Home

Evaluator's Name:
Jeri Gilb, RN, MSN, CNP, Special Investigator

Finding: Not Substantiated

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.

Initial Investigation Allegation(s):
It is alleged the alleged perpetrator (AP), a facility staff, abused a resident when she forced the resident to take medication by putting the medication in the resident's mouth after he said no.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated.
Although the AP stated she put medication in the resident's mouth after he verbally told her no, she denied using physical force or restraint to administer the medication. This was an isolated incident and no harm occurred to the resident. Delay of administration of Parkinson's medication can cause increased rigidity and tremors, resulting in undue discomfort to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, employee training, and facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included Parkinson's disease, hallucinations, and dementia. The facility assisted the resident with medication management, bathing, dressing, and grooming.

During an interview, a facility staff person stated she witnessed the AP force the resident's medication into his mouth after he said no. The staff person stated the AP put the spoon in his mouth and told him to stop acting like a child. The staff person stated the resident coughed and spat the medication out and then yelled for the AP to get out of his room. The staff person stated the resident was tearful after the AP left the room and she calmed him before she reported the incident to facility nursing. The facility staff person denied there was a physical injury from the incident, and indicated the AP did not restrained or injure the resident when she administered the medications. The staff person stated the AP put the spoon up to the resident's lips and then in his mouth when he opened his mouth.

During an interview the AP stated the resident had Parkinson's disease and she knew if he missed his medication for Parkinson's disease, he would be very uncomfortable. The AP stated the resident told her no, but when he opened his mouth, she put the spoonful of medications in his mouth. The AP stated the resident was angry and spit some of the medication out. The AP stated she told the resident not to spit. The AP denied the resident coughed or choked. The AP denied holding the resident's head or hands in restraint to give the medication. The AP stated she held the spoon to his mouth and then waited for him to open his mouth to put the spoon into his mouth. The AP stated the head of the bed was slightly elevated. The AP stated there was no injury to the resident and she believed she was helping the resident by giving the medication to prevent tremors.

During an interview, the nurse leadership stated a facility staff reported she witnessed the AP give medications to the resident after he said no. When the nurse interviewed the AP, she admitted she gave the resident medication after he said no, but that she did not force or restrain the resident when she administered the medication. The nurse stated the reporting staff denied the AP restrained or injured the resident when she administered the medication. The nurse stated the AP received discipline after the incident and the facility retrained the AP in resident refusals, difficult behaviors, and dementia. The nurse denied any prior concerns regarding abuse or neglect by the AP. The nurse stated there was no injury or harm to the resident.

During an interview, other facility nursing staff stated a staff person reported she witnessed the AP force the resident to take medication after he said no, which upset the resident. The nursing staff stated the resident reported the AP had forced him to take his medication and it made him cough and choke. The facility nurse stated when the resident reported the incident he was upset, but not tearful. The facility nurse denied the AP injured or harmed the resident when the AP administered the medication. The resident did not require any medical treatment because of the incident. The facility nurse stated she had no concerns about the safety of residents with the AP.

In conclusion, the Minnesota Department of Health determined, abuse was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Unable.
Family/Responsible Party interviewed: Unable.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Re-educated AP, follow up meetings with nursing leadership to monitor progress.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc: The Office of Ombudsman for Long-Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00725	A. BUILDING: _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CTR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 HZ343002M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		