Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H40147486M
Compliance #: H40143572C

Date Concluded: March 2, 2024

Name, Address, and County of Licensee Investigated:
Community Behavioral Health Hospital Bemidji
800 Bemidji Avenue North Suite 200
Bemidji, MN 56601
Beltrami County

Facility Type: Hospital

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
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):
The alleged perpetrator (AP), who is also a nurse, neglected a patient when the AP failed to follow the patient's care plan and forced the patient to walk after a recent fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The patient's care plan indicated she often complained of pain with walking and staff encouraged independence. The patient had a fall prior to the incident and an x-ray showed no fractures. The patient's care plan remained unchanged. After the AP assisted the patient to walk, the AP observed increased pain and difficulty walking. The AP called the on-call doctor and reported the patient's change of condition. The patient was sent to the hospital where a second x-ray confirmed a broken bone.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, internal investigation, facility policies, personnel records, and video footage of incident.

The patient resided in a behavioral health hospital. The patient's diagnoses included major depressive disorder with psychotic features, and anxiety disorder. The patient's service plan included assistance with managing mental health symptoms, medication management, falls prevention, and encourage independence and activities. The patient's assessment indicated she verbalized delusional and paranoid thoughts.

Per the video record of the incident, the AP was observed encouraging the resident to stand. The AP and an unlicensed personnel (ULP) assisted the patient to stand by lifting the patient from under her arms. Although the patient appeared weak and unsteady, the patient was able to stand independently and bear weight. The AP and ULP assisted the patient to walk. There were three video records of the AP, along with several other staff assisting the patient to walk. In one video, the AP and a nurse used a gait belt to walk the patient.

According to the patient's care plan, the patient had no care planned directions with walking. The care plan indicated staff to encourage independence.

The internal investigation indicated the patient was sent to the hospital for increased level of pain on the afternoon of the incident and a fracture was discovered.

During an interview, a member of management said she watched video footage of the incident where the AP and a few other staff walked the patient despite complaints of pain. She said the patient fell a few days prior and had walked independently since the fall. The patient had an x-ray that indicated no broken bones. The patient had a history of somatic (unexplained symptoms without diagnosis) complaints of pain. Staff encouraged independence and the care plan was never updated after the fall. The member of management said the AP made hand gestures directing the patient to stand up. It was reported to management, the AP was persistent and sounded aggressive when she encouraged the patient to stand and walk to the phone. The AP had no prior history of similar incidents and no prior disciplinary action. The management member said the AP tried to do the right thing by encouraging the patient to be independent and described the AP as kind.

During an interview, the ULP said the AP was persistent with her attempts to encourage the patient to walk. She said she felt uncomfortable trying to get the patient to walk but she did not say anything. She said she reported her concerns the next day after the fracture was found.

During an interview, the AP said the patient fell a week before the incident. The x-ray indicated no broken bones and the patient had been walking throughout the week. She said the patient complained of pain daily and often declined to walk. She encouraged the patient to walk and assisted her up from the chair with help from an ULP. While assisting the patient, the patient

complained of more pain than usual, and she knew something was wrong. She called the on-call doctor and reported her assessment. The doctor ordered another x-ray, and the patient was sent to the hospital. A fracture was confirmed at the hospital.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, never responded to interview request.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The facility provided education to all staff.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act

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
	25049	A. BUILDING: _____ B. WING _____	C 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY BEHAVIORAL HEALTH HOSPITAI	800 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(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
6 000	INITIAL COMMENTS The Minnesota Department of Health investigated an allegation of maltreatment, complaint H40147486M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	6 000		