

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52282483M

Date Concluded: January 10, 2023

Name, Address, and County of Licensee

Investigated:

Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258
Lyon County

Facility Type: Nursing Home

Evaluator's Name:

Lisa Coil, RN
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):

The alleged perpetrator (AP) abused the resident when the AP called the resident a “bitch” and said to the resident “stop being a bitch.”

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. While there was conflicting evidence the event occurred, the investigation found the event was isolated and not repeated behavior on the part of the AP.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator conducted an interview with the resident's family member. The investigator reviewed the resident's medical record, the facilities policies, procedures, and internal investigation.

The resident resided in a nursing home. The resident's diagnoses included dementia. The resident's care plan indicated the resident was dependent on staff to complete daily cares and administer medications. The care plan also indicated the resident had difficulty understanding others, making herself understood, had unclear speech, and impaired decision-making.

The resident's medication record did not indicate the resident had a change in medications or medication usage following the incident.

During an interview, the family member (FM) stated the resident had severe dementia and did not always like to do everything she needed to do, such as take medications sometimes. The FM stated she believed the resident's depth of illness would have prevented the effects of emotional abuse from occurring to the resident.

During an interview, the unlicensed personnel (ULP), stated the resident was nonverbal and did not always understand what was going on. The ULP stated it was normal for the resident to put her hands up and spit out medications during medication administration. The ULP stated the resident was putting her hands in the way during medication administration and the AP called the resident a "bitch". The ULP stated she had never heard the AP call the resident a "bitch" prior to this incident. The ULP reported the incident to her supervisor.

During an interview, the AP, also an unlicensed personnel (ULP), denied calling the resident a "bitch" or stating "stop being a bitch" to the resident.

There were no other witnesses to the event.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility investigated the incident and followed their policies and procedures related to the incident.

Action taken by the Minnesota Department of Health:

No further action at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00343	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2022
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NAME OF PROVIDER OR SUPPLIER avera morningside heights care cente	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52282483M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.</p>	2 000		

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

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER AVERA MORNINGSIDE HEIGHTS CARE CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258
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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		